CareFirst BlueCross BlueShield

A

Health Benefits Program

Prepared For

The Actives and Retirees In

The Montgomery County Government

High Option and Standard Option

Point-of-Service Plan

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For Your Reference

- Member Service Representatives are available to answer benefit and claim inquiries Monday through Friday from 8:00 a.m. until 8:00 p.m., Eastern Standard Time (ET). Please contact Member Service at 1-888-417-8385.

- You can also send written inquiries to Member Service at:

CareFirst BlueCross BlueShield
National Accounts Dedicated Services
P.O. Box 1739
Cumberland, MD 21501

- To authorize inpatient medical services, please contact Utilization Management at the telephone number indicated on your identification card.

- To authorize inpatient mental health/substance abuse services, please call the telephone number indicated on your identification card.

Introduction

Montgomery County is pleased to offer you and your family access to excellent health care coverage. The Point-of-Service (POS) Plan administered by CareFirst BlueCross BlueShield (CareFirst), enables employees, retirees and their families to receive affordable health care while utilizing a POS style plan.

Overview

This Summary of Benefits (SB) describes the benefits offered under the POS Program. Keep this SB in a handy location, so that you can refer to it when necessary. Refer to it when you need to find out information quickly or if you just want to know what your coverage includes.

If you have a question that is not covered in this SB, call Member Service toll-free at 1-888-417-8385.

How to Use this Summary of Benefits (SB)

This SB is meant to be informative and easy to understand. It was written to help you learn how your benefits work and how to use them most effectively. Please take some time to read through the SB. When faced with a benefit question, you will know where to turn in the SB for your answer.

The information provided in this SB summarizes your benefit plan. Montgomery County reserves the right to change, amend or terminate the plan at any time. This SB is not a contract and participation in this plan does not guarantee employment.

Understanding Key Terms

Certain key terms that relate to your benefits are used throughout this handbook. Those terms are defined in the Definitions Section of this SB.

Highlights of the Point-of-Service Plan

- The Plan covers most of your healthcare needs and enables you to choose where to receive services:
  - from your PCP you selected. By doing so, you will be covered in-network, which means you will incur the least out-of-pocket expense and will not have to file a claim;
  - from a Participating Provider who contracts with CareFirst to provide services at a fixed cost (Participating Providers are not always in-network providers);
  - from any other covered provider that CareFirst recognizes as an eligible provider of medical services (Non-Participating Provider).

- The Plan has an Open Access feature, which allows you to choose a PCP to coordinate your care, but you can visit specialists such as dermatologists, podiatrists and other specialist without a referral. You can also self-refer to providers in either the Maryland Point-of-Service Network or the CareFirst BlueChoice Network. All Members must select a PCP to receive In-Network services. A Member may choose a PCP from either of the Provider Networks.

- When you go to a Participating Provider, that is out-of-network, you are covered at a percentage of the Allowed Benefit after you have met your annual deductible. Participating Providers have agreed to accept the Allowed Benefit as payment in full for covered services. You will also have no claims to file and you will not be billed for any amount over the allowed amount. You or your Participating Provider must obtain any required authorization.

- Non-Participating providers are doctors and hospitals that do not participate with CareFirst. When you go to a Non-Participating Provider you need to coordinate your own care and obtain any required authorization. You may need to pay for services up-front and then file claim forms for reimbursement. Non-Participating Providers may not accept the Allowed Benefit as payment in full for covered services. You may be responsible for paying any charges that exceed the Allowed Benefit.

- Covered services include the following if medically necessary:

  - doctor's office visits;
  - laboratory tests and X-rays;
  - preventive care;
  - inpatient and outpatient hospital services;
  - mental health and substance abuse services.

How the Point-of-Service Plan Works

The Choice Is Yours

The following table shows the steps involved when you choose to go to an in-network provider or an out-of-network provider for medical care.

<table>
<tr><td>In-Network</td><td>If you see your In-Network PCP provider
You pay a Copayment
No need to file claim forms</td><td>If you need hospitalization, home health care or hospice services
Your provider will obtain necessary approval and arrange services
You file no claim forms</td></tr>
<tr><td rowspan="2">Out-of-Network</td><td>If you see an Out-of-Network Participating Provider
After you meet your annual deductible, the plan pays out-of-network benefits directly to the provider
You are responsible for paying a percentage of the cost of covered services</td><td>If you see a Non-Participating Provider
You may need to pay the full amount of services immediately
File a claim and, after you have met your annual deductible, receive reimbursement of Allowed Benefit for services</td></tr>
<tr><td colspan="2">If you need hospitalization, home health care or hospice services:
Call the Utilization Management section of CareFirst for approval of services
Pay your bills at the time of service, or authorize your provider to file a claim
You may be responsible for paying any expenses not covered by the plan
File claim forms</td></tr>
</table>

Out-of-Pocket Costs

Your out-of-pocket costs will depend on the type of provider you or your family members see when you need care:

- In-Network
- Out-of-Network

Annual deductible

When you seek care In-Network from your PCP, you are not required to satisfy an annual deductible. For most Out-of-Network services, you must first meet an annual deductible before the program will begin to pay benefits. The following deductibles will apply:

Individual coverage	$300
Family coverage	$600

If you have family coverage, the family deductible can be met by any number of family members — however, one family member may not contribute more than the individual deductible toward the family limit. Once the family deductible is met, the deductible for all covered family members will be satisfied.

After you meet the deductible, you will also be responsible for coinsurance.

Copayment A Copayment is the portion that you pay at the time services are received. In most cases, your Copayment for services rendered by your PCP, as well as those services rendered by a specialist, typically require a $10 Copayment when covered under the High Option Program and a $15 Copayment when covered under the Standard Option Program. For a more complete list of Copayment amounts refer to the Schedule of Benefits or call Member Services at 1-888-417-8385.

Coinsurance For out-of-network services, you are responsible for a percentage of the cost of services you receive, called coinsurance. For most services, you will pay a percentage of the Allowed Benefit (usually 20%).

Out-of-pocket maximum If you or a covered family member gets seriously hurt or sick, your medical expenses could be quite high. Once you have met your out-of-pocket maximum, the plan pays 100% of the Allowed Benefit for your covered medical expenses. The following out-of-pocket maximum will apply:

Individual Out-of-Pocket maximum is $1,000

NOTE: The following items do not contribute toward out-of-pocket expense limits:

- charges above the Allowed Benefit for services rendered by any Non-Participating Provider
- penalties for failure to comply with the Utilization Management Program
- non-covered services
- services applied to the calendar year deductible

Filing a Claim

If you see a Non-Participating Provider, you are responsible for filing a claim form, or for ensuring that your doctor's office or hospital files one for you. As previously discussed, if you see your PCP, a specialist your PCP referred you to or a Participating Provider, you will not need to file a claim.

Claim forms are available by calling Member Service at 1-888-417-8385. Attach an itemized bill to your completed claim form and submit it to:

CareFirst BlueCross BlueShield
National Accounts Dedicated Services
P.O. Box 1739
Cumberland, MD 21501

All In-Network claims must be filed ninety (90) days after the date the services were rendered or supplies were received. You are only responsible for filing claims for urgent or emergency care services that were provided by an Out-of-Network Provider. In this instance, you are also responsible for providing information requested by CareFirst, including medical records.

All claims being filed under the Out-of-Network portion of the Point-of-Service Plan must be submitted within fifteen (15) months after the date the services were rendered or supplies were received.

You should keep copies of all bills for your records. Your original bills will not be returned.

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

PROGRAM DESCRIPTION

The Group reserves the right to change, modify, or terminate the Plan, in whole or in part.

Members have no benefits after a Plan termination or partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial Plan termination and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state or local law.

Members should not rely on any oral description of the Plan, because the written terms in the Group's Plan documents always govern.

To the extent that this health care benefits plan is completely or partially self-funded by the Group, CareFirst provides administrative services only and does not assume any financial risk or obligation with respect to health care benefit claims for the self-insured portion of the Contract.

SECTION 1
DEFINITIONS

1.1 This Program Description uses certain defined terms. When these words are capitalized, they have the following meanings.

Anniversary Date means the date specified in the Administrative Service Agreement (ASA), on which the Contract renews and each annual anniversary of such date.

Benefit Guide means the summary description of the program provided to all Members. In the event of a conflict between the summary description and this complete Program Description, the language of this Program Description governs.

BlueChoice means CareFirst BlueChoice, Inc.

BlueChoice Physician means a licensed doctor who has entered into a contract with CareFirst BlueChoice, Inc. to provide services to Members and who has been designated by BlueChoice as a BlueChoice Physician.

BlueChoice Provider is any physician, health care professional or health care facility that has entered into a contract with CareFirst BlueChoice, Inc. and has been designated by BlueChoice to provide services to Members under the Contract.

CareFirst means Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield.

Claims Administrator means CareFirst.

Contract means the agreement issued by CareFirst to the Employee/Member's Group through which the benefits described in this Program Description are administered to the Employee/Member and his enrolled Dependents, if any. In addition to this Program Description, the Contract includes an Administrative Services Agreement, Attachments, any Riders or Amendments and the Benefit Guide.

Conversion Contract means a non-group health benefits contract issued in accordance with applicable federal, local and state laws and regulations to individuals whose coverage through the Group has terminated.

Dependent means a person who meets the eligibility rules in Section 2, Eligibility and Enrollment.

Domestic Partner means a person who meets the eligibility rules in Section 2, Eligibility and Enrollment.

Effective Date means the date on which the Group Contract becomes effective and on which Members first become eligible to receive benefits and services under the Contract. The Effective Date is set forth in the Administrative Services Agreement.

Eligible Employee/Member means persons who meet the eligibility rules in Section 2, Eligibility and Enrollment.

Enrollment Application/Form means the information submitted by or on behalf of an eligible individual in connection with a request to enroll under the Contract as either an Employee/Member or a Dependent.

Experimental or Investigational means a service or supply that is in the developmental stage and in the process of human or animal testing excluding Clinical Trial Patient Cost Coverage as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below

are deemed to be Experimental/Investigational:

1. The Technology* must have final approval from the appropriate government regulatory bodies;

2. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;

3. The Technology must improve the net health outcome;

4. The Technology must be as beneficial as any established alternatives; and,

5. The improvement must be attainable outside the Investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

Group Contract means the Contract issued by CareFirst to the Group/Sponsor.

Group/Sponsor means the Employee/Member's employer or other organization that sponsors a health benefits plan to which CareFirst has issued the Contract.

Hospital means any facility in which the primary function is the provision of diagnosis, treatment, and medical and nursing services, surgical or non-surgical and that is:

A. Licensed by the appropriate State authorities; or

B. Accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

C. Approved by Medicare.

The facility cannot be, other than incidentally: a convalescent home, convalescent rest or nursing facilities; facilities primarily affording custodial, educational or rehabilitative care; or facilities for the aged, drug addicts or alcoholics.

Limiting Age means the age to which a Subscriber may cover his/her unmarried Dependent Children as stated in Section 2, Eligibility and Enrollment.

Maryland Point-of-Service Program Option or "Program" means the coverage available to Eligible Members who elect to enroll in the Maryland Point-of-Service Program Option through which Members may receive Covered Services from either an In-Network provider or from an Out-of-Network Provider.

Medical Director is a board-certified physician who is appointed by CareFirst. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary (or Medical Necessity) means use of a service or supply that is:

1. Commonly and customarily recognized as appropriate in the diagnosis and treatment of a Member's illness or injury;

2. Appropriate with regard to standards of good medical practice;

3. Not solely for the convenience of the Member, his or her physician, hospital, or other Health Care Provider; and,

4. The most appropriate supply or level of service that can be safely provided to the Member.

The term "not Medically Necessary" means the use of a service or supply that does not meet the above criteria for determining medical necessity. The decision as to whether a service or supply is Medically Necessary for purposes of payment by CareFirst rests with the Medical Director or his/her designee; however, such a decision shall in no way affect the provider's/practitioner's determination of whether medical treatment is appropriate as a matter of clinical judgment.

Member means an individual who meets all applicable eligibility requirements and is enrolled either as a Subscriber or as a Dependent, and for whom the appropriate payments have been received by CareFirst.

Paid Claims is the amount paid by CareFirst for Covered Services under the Plan. The following are also included in Paid Claims:

A. BlueCard Fees and Compensation;

B. Third-party vendor fees.

Plan means that portion of the Welfare Benefit Plan established by the Group that provides for health care benefits for which CareFirst is the Claims Administrator under this Group Contract.

Plan Administrator means the person or persons designated by the Group.

Point-of-Service Program Option or "Program" means the coverage available to Eligible Members who elect to enroll in the Point-of-Service Program Option through which Members may receive Covered Services from either an In-Network provider or from an Out-of-Network Provider.

Program Description means this document. In addition to this Program Description, the Contract includes an Administrative Services Agreement, Attachments, any Riders or Amendments and the Benefit Guide.

Service Area means the geographic area within which BlueChoice's services are available. The Service Area is as follows: the District of Columbia; the State of Maryland; and the following Virginia counties and cities - Arlington, Alexandria, Fairfax, City of Fairfax, Falls Church, Prince William, Manassas, Manassas Park, Loudoun, and Leesburg. CareFirst may amend the defined Service Area at any time, with notification to the Group.

Specialist is a licensed health care provider to whom a Member can be referred to by a Primary Care Physician.

Subscriber means a Member who is covered under the Contract as an Employee/Member, rather than as a Dependent.

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage. The Group is required to administer all requirements for coverage in strict accordance with the terms that have been agreed to and cannot change the requirements for coverage or make an exception unless CareFirst approves them in advance, in writing. To be covered under the Contract, all of the following conditions must be met:

A. The individual must be eligible for coverage either as an Employee/Member pursuant to Section 2.2, below or, if applicable, as a Spouse, Domestic Partner or Dependent pursuant to Section 2.3 or 2.4 below;

B. The individual must elect coverage during certain periods set aside for this purpose as described in Section 2.6, below;

C. The Group must notify CareFirst of the election in accordance with the Group Contract; and

D. Payments must be made by or on behalf of the Member as required by the Group Contract.

2.2 Eligibility as an Employee/Member. To be eligible as an Employee/Member, the individual must meet the basic requirements as stated below and any additional eligibility requirements to which the Group has agreed. These are set below and in the Group Application (available through your Group).

A. Basic Plan Requirements. You must be a permanent active or retired employee of the Group or of one of the participating agencies of the Group, or in a class of temporary employees eligible for benefits.

B. Additional Eligibility Requirements. In addition to the basic eligibility requirements in Section 2.2.a., above, you must meet the additional eligibility requirements that are listed in the Group Application. The Group is required to administer these requirements in strict accordance with the terms that have been agreed to and cannot change the requirements or make an exception unless we approve them in advance, in writing.

2.3 Eligibility of Employee/Member's Spouse or Domestic Partner. An Employee/Member may elect Family or Subscriber and Spouse or Domestic Partner Coverage; an Employee/Member may cover his/her legal spouse or Domestic Partner as a Dependent. An Employee/Member cannot cover a former spouse once divorced or if the marriage has been annulled. If an Employee/Member is separated but still legally married, his or her spouse may still be covered.

2.4 Eligibility of Employee/Member's Dependent Children. The Group may elect to provide coverage for eligible Dependent Children. To be eligible as a Dependent Child, the child must:

A. Meet the age requirements described in Section 2.5 below;

B. Be unmarried; and

C. Be related to the Employee/Member, in one of the following ways:

1. A natural child;

2. A legally adopted child or grandchild;

3. A child (including a grandchild) for whom the Employee/Member is the legally recognized proposed adoptive parent and who is dependent upon and living with the Employee/Member during the waiting period before the adoption becomes final;

4. A stepchild who permanently resides in the Employee/Member's household and who is dependent upon the Employee/Member for more than half of his or her support;

5. A grandchild who is in the court ordered custody of and is dependent upon and residing with the Employee/Member;

6. A child for whom the Employee/Member has been court ordered or administratively ordered to provide coverage;

7. Children whose relationship to the Employee/Member are not listed above, are not covered under the Contract, even though the child may live with the Employee/Member and be dependent upon the Employee/Member for support. CareFirst has a right to request documentation from the Employee/Member that a child qualifies for coverage as a Dependent.

8. The child of the Employee/Member's Domestic Partner who permanently resides in the Employee/Member's household and is dependent upon the Employee/Member, for more than half of his or her support.

2.5 Age Limits for Coverage of Dependent Children (Limiting Age). All Dependent Children are eligible for coverage up to the Limiting Age for non-students, as stated below:

Dependent Children may be eligible beyond the Limiting Age if they meet the requirements for Student Dependents, as described below:

A. All Dependent Children are eligible up to age 19;

B. Children who are age 19 or over are eligible up to age 26 if attending an accredited school, college or university on a full time basis. Student Dependent means a Dependent Child whose attendance at an accredited institution at which he/she is enrolled meets the institution's requirements for full time status. The Member must provide CareFirst with proof of the child's student status, within 31 days after the child's 19th birthday, or coverage would otherwise terminate or within 31 days after the Effective Date of the child's coverage under the Contract, whichever is later. CareFirst has the right to verify whether the child is and continues to qualify as a Dependent or Student Dependent.

C. A Dependent Child will be eligible for coverage past the Limiting Age of 19 if:

1. The child is incapable of supporting him or herself because of mental or physical disability;

2. The disability occurred before the child reached the Limiting Age or, if the child was covered beyond the Limiting Age as a non-Student or Student Dependent, the disability occurred before the child reached the Limiting Age;

3. The child is primarily dependent upon the Employee/Member or the Employee/Member's spouse or Domestic Partner for support and maintenance; and

4. The Member provides CareFirst with proof of the child's certified medical incapacity, within 31 days after the child's coverage would otherwise terminate or within 31 days after the Effective Date of the child's coverage under the Contract, whichever is later. CareFirst has the right to verify whether the child is and continues to qualify as an incapacitated child.

2.6 Enrollment Requirements. Eligible individuals may elect coverage as Employee/Members or Dependents, as applicable, only during the following times and under the following conditions:

A. **Annual Open Enrollment**. Prior to January 1 of each year that the Group Contract is in effect, the Group will have an Open Enrollment Period as announced by the Group. During the Open Enrollment Period, Eligible Subscribers who are not covered may enroll themselves and their Dependents in the Plan. In addition, enrolled Subscribers may change their Type of Coverage and/or add eligible Dependents not previously enrolled to their coverage, or change plan options. Your coverage will become effective on January 1.

B. **Newly Eligible Employee/Member**. Newly eligible individuals may enroll within 31 days after they first become eligible as determined within Section 2, Eligibility and Enrollment. If such individuals do not enroll within this period and do not qualify for the Special Enrollment Period as described in Section 2.6.F, Special Enrollment Periods, they must wait for the Group's next open enrollment period.

C. **Coverage of a Newborn, Newly Adopted Child, Newly Eligible Grandchild or a Minor to whom Guardianship is granted by Court or Testamentary Appointment**. Employee/Members may enroll new family members, such as an eligible newborn child, newly adopted child, newly eligible grandchild or a minor for whom guardianship is granted by court or testamentary appointment and/or change their Membership Category to include the new family member within 31 days following the date the new family member first becomes eligible. If this election is not made within this period and the new family member does not qualify for the Special Enrollment Period as described in Section 2.6.F, the new family member(s) may not enroll until the Group's next open enrollment period. The date of the child's First Eligibility Date is defined below:

First Eligibility Date:

1. For a newborn child, the child's date of birth;

2. For a newly adopted child, the earlier of; a judicial decree of adoption; or date of assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive parent;

3. For a grandchild for whom the Employee/Member has been granted legal custody, the date of the court decree or the date the court decree becomes effective, whichever is later;

4. For a minor for whom guardianship has been granted by court or testamentary appointment, the date of the appointment.

Family Coverage. If the Employee/Member is already enrolled under Family Coverage on the child's First Eligibility Date, an eligible newborn child, newly adopted child, newly eligible grandchild or a minor for whom guardianship has been granted by court or testamentary appointment will be covered automatically as of the child's First Eligibility Date.

Individual Coverage. If the Employee/Member is enrolled under Individual Coverage on the child's First Eligibility Date, the child will be covered automatically, but only for the first 31 days following the child's First Eligibility Date. The Employee/Member may continue coverage beyond this 31 day period, but the Employee/Member must enroll the child within 31 days following the child's First Eligibility Date. Premium changes resulting from the addition of the child will be effective as of the child's First Eligibility Date.

Two-Party Coverage. If the Employee/Member is enrolled under Two-Party coverage (e.g., Employee and spouse or Domestic Partner or Employee and one child) on the child's First Eligibility Date, the child will be covered automatically as of the child's First Eligibility Date. However, if adding the child to the coverage results in a change in the Employee/Member's Membership Category (e.g., from Two-Party coverage to Family Coverage), the child's automatic coverage will end on the 31st day following the child's First Eligibility Date. If the Member wishes to continue coverage beyond this 31 day period, they must enroll him or her within 31 days following the First Eligibility Date. The change in the Membership Category and corresponding premium for the Employee/Member's new Membership Category will be made effective as of the child's First Eligibility Date.

D. **New Family Member (Other than a newborn or newly adopted child or newly eligible grandchild or a minor to whom guardianship is granted by court or testamentary appointment).** The Employee/Member may enroll new family members, such as a new spouse, Domestic Partner or stepchild, and/or change the Membership Category to include the new family member within 31 days following the date the new family member first becomes eligible. If this election is not made within this period and the new family member does not qualify for the Special Enrollment Period as described in Section 2.6.F, the new family member(s) may not enroll until the Group's next open enrollment period.

First Eligibility Date:

1. Spouse - The date the marriage is legally recognized.

2. Domestic Partner - The date established by the Group's enrollment procedures.

3. Stepchild or child of a Domestic Partner - If the child meets the definition of a Dependent Child under Section 2.4, the First Eligibility Date will be the same as that of the spouse or Domestic Partner. Otherwise, the First Eligibility Date for the child will be the date on which the child first meets the definition of Dependent Child under Section 2.4.

E. **Coverage of Children under Court or Administrative Order**. If the Employee/Member has been ordered by a court or administrative agency to provide coverage under this Contract for his or her Dependent child (or children), the Employee/Member may enroll the eligible minor Dependent child (or children) included in the order within 31 days following the date on which the order was signed by a competent court or administrative agency. If the Group is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Group will determine whether an order received by the Group with respect to employees of the Group and their children is a "qualified medical child support order" (as that term is defined under ERISA) and whether such children are eligible for coverage under that qualified medical support order.

F. **Special Enrollment Periods.** Special enrollment is allowed for certain individuals who lose coverage. Special enrollment is also allowed with respect to certain Dependent beneficiaries.

If only the Subscriber is eligible under this Contract and Dependents are not eligible to enroll, special enrollment periods for a spouse/Dependent child are not applicable.

1. Special enrollment for certain individuals who lose coverage:

   a. CareFirst will permit current employees and Dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Contract.

   b. Individuals eligible for special enrollment.

      1) When employee loses coverage. A current employee and any Dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:

         a) The employee and the Dependents are otherwise eligible to enroll;

         b) When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

         c) The employee satisfies the conditions of paragraph 1.c)1), 2), or 3) of this section, and if applicable, paragraph 1.c)5) of this section.

      2) When Dependent loses coverage.

         a) A Dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit packaged offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:

            i) The Dependent and the employee are otherwise eligible to enroll;

            ii) When coverage was previously offered, the Dependent had coverage under any group health plan or health insurance coverage; and

            iii) The Dependent satisfies the conditions of paragraph 1.c)1), 2), or 3) of this section, and if applicable, paragraph 1.c)4) of this section.

         b) However, CareFirst is not required to enroll any other Dependent unless the Dependent satisfies the criteria of this paragraph 1.b)2), or the employee satisfies the criteria of paragraph 1.b)1) of this section.

   c. Conditions for special enrollment.

1) Loss of eligibility for coverage. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph 1)c)1) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage. Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:

   a) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;

   b) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

   c) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual;

   d) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

   e) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes that individual.

2) Termination of employer contributions. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph are satisfied at the time employer contributions towards the employee's or Dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.

3) Exhaustion of COBRA continuation coverage. In the case of an employee or Dependent who has coverage that is COBRA

continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph 1)c)1) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.

4) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any Dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any Dependent of the employee under this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph if the employee provides a written statement that coverage was being declined because the employee or Dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)

2. Special enrollment with respect to certain Dependent beneficiaries:

a. Provided the Group provides coverage for Dependents, CareFirst will permit the individuals described in paragraph 2.b. of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Contract.

b. Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph 2.b)1), 2), 3), 4), 5), or 6) of this section.

1) Current employee only. A current employee is described in this paragraph if a person becomes a Dependent of the individual through marriage, birth, adoption, or placement for adoption.

2) Spouse of a participant only. An individual is described in this paragraph if either:

a) The individual becomes the spouse of a participant; or

b) The individual is a spouse of a participant and a child becomes a Dependent of the participant through birth, adoption, or placement for adoption.

3) Current employee and spouse. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:

a) The employee and the spouse become married; or

b) The employee and spouse are married and a child becomes a Dependent of the employee through birth, adoption, or placement for adoption.

4) Dependent of a participant only. An individual is described in this paragraph if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, adoption, or placement for adoption.

5) Current employee and a new Dependent. A current employee and an individual who is a Dependent of the employee, are described in this paragraph if the individual becomes a Dependent of the employee through marriage, birth, adoption, or placement for adoption.

6) Current employee, spouse, and a new Dependent. A current employee, the employee's spouse, and the employee's Dependent are described in this paragraph if the Dependent becomes a Dependent of the employee through marriage, birth, adoption, or placement for adoption.

2.7 Effective Dates. Coverage for an Employee/Member or his or her Dependents will become effective as stated below as long as the Enrollment Requirements in Section 2.6 are satisfied.

A. **Open Enrollment Effective Date**. Enrollment or changes in enrollment will be effective January 1, 2006, which is the Group's Open Enrollment Effective Date/Anniversary Date, if the requirements of Section 2.6.A are met.

B. **New Employee/Members.** Coverage of new Employee/Members will be made effective on the as determined by the Employee/Members Office of Human Resources if the requirements of Section 2.6.B are met.

C. **Coverage of Newborn Children, Newly Adopted Children and Newly Eligible Grandchildren**. Coverage will become effective as of the child's First Eligibility Date as stated in Section 2.6.C, if the requirements of Section 2.6.C are met.

D. **Coverage of Other Newly Eligible Dependents**. Coverage of other newly eligible Dependents; e.g., a new spouse, Domestic Partner, stepchild or child of a Domestic Partner, will be made effective in accordance with the Eligibility Date stated in Section 2.6., provided the newly eligible Dependent is enrolled within 31 days following the date upon which the Dependent first became eligible.

E. **Coverage of Children under Court or Administrative Order**. Coverage of the Dependent Child under a court or administrative order will become effective on the first day of the month following our receipt of the Enrollment Form or as otherwise required by the court or administrative order or applicable law as stated in Section 2.6.E, if the requirements of Section 2.6.E are met.

2.8 Employee/Member's Coverage Changes. When the Employee/Member's Membership Category is changed (e.g., from Individual to Family coverage) the change may become effective on any day throughout the month. Charges for Members enrolled during the month will be calculated on a pro-rata basis unless otherwise agreed to between the Group and CareFirst.

2.9 Domestic Partner Eligibility. The Group and CareFirst may require proof of any of the following qualifications at any time:

A. **Eligibility of Employee/Member's Domestic Partner**. The following persons are also eligible for benefits under the Contract:

1. The Subscriber's Domestic Partner.

2. The Eligible Dependents of a Domestic Partner.

A Domestic Partner and the Eligible Dependents of a Domestic Partner remain eligible only for the period that the Domestic Partnership continues.

A person who is related to the Subscriber; e.g., parent, grandparent, sibling, cousin, aunt, uncle, etc. is not eligible.

B. **Definitions**

Domestic Partner is a person who cohabitates/resides with the Subscriber in a Domestic Partnership and the Eligible Dependents of a Domestic Partner.

Eligible Dependent of a Domestic Partner is an unmarried person who has the same relationship to a Domestic Partner that is required of an Employee/Member's Dependent Children as defined herein.

Domestic Partnership is a relationship between a Domestic Partner and a Subscriber both of whom have signed the appropriate affidavit, enrollment application, or other document(s) required by the Group confirming their Domestic Partnership and that satisfies the following requirements:

1. They are the same sex (or opposite sex for members of the Federal Order of Police (FOP), effective July 1, 2001 and for members of the International Association of Fire Fighters (IAFF), effective July 1, 2002);

2. They share a close personal relationship and be responsible for each other's welfare;

3. They have shared the same legal residence for at least 12 months;

4. They are at least 18 years old;

5. They have voluntarily consented to the relationship, without fraud or duress;

6. They are not married to, or in a domestic partnership with, any other person;

7. They have not related by blood or affinity in a way that would disqualify them from marriage under State law if the employee and partner were opposite sexes;

8. They are legally competent to contract;

9. They share sufficient financial and legal obligations; or

10. They have legally registered the Domestic Partnership, if

    - A Domestic Partnership registration system exist in the jurisdiction where the employee resides; and

    - The Office of Human Resources determines that the legal requirements for registration are substantially similar to the requirements listed under 1 above.

The Employee/Member must provide evidence of the Domestic Partnership. The Employee/Member must provide the following:

1. The Affidavit For Domestic Partnership signed in the presence of a notary public by both the Employee/Member and the Employee/Member's Domestic Partner under penalty of perjury declaring that they satisfy the requirements of Domestic Partnership; or

2. An official copy of the Domestic Partnership registration, and;

3. Evidence that the Employee/Member and the Domestic Partner share items described in at least 2 of the following (this requirement does not apply to a qualified, registered domestic partnership):

    - Joint housing lease, mortgage, or deed;

    - Joint ownership of a motor vehicle;

    - Joint checking or credit account;

    - Designation of the partner as the primary beneficiary of the employee's life insurance, retirement benefits, or residuary estate under a will; or;

    - Designation of the partner as holding a durable power of attorney for health care decisions regarding the employee.

C. **Enrollment Requirements and Effective Date**. A Domestic Partner must

1. File a notarized Affidavit For Domestic Partnership, with all required supporting evidence with the Office of Human Resources (affidavit form is attached);

2. Within 60 days of filing the affidavit with all required supporting evidence,

    - Complete a benefit enrollment form, when changing your level of coverage due to the addition of the Domestic Partner and Eligible Dependents of a Domestic Partner;

    - Complete a dependent information form to add the Domestic Partner and Eligible Dependents of a Domestic Partner (Note - Proof of eligibility, such as a birth certificate, is required to add Eligible Dependents of a Domestic Partner to the group insurance plans); and

- Complete any forms required by the group insurance plan to add Eligible Dependents of a Domestic Partner.

Eligible Dependents of a Domestic Partner are enrolled in the same manner as a child and will have the same Effective Dates as a child.

D. Termination of Coverage. The Subscriber agrees to notify the Group in writing of the termination of the Domestic Partnership within 30 days of the date of termination. In such case, benefits will terminate or continue for the Domestic Partner and any Eligible Dependents of a Domestic Partner as they would for any other Member.

E. **Continuation Privilege**. A Domestic Partner and the Eligible Dependents of a Domestic Partner are eligible for Continuation of Coverage under Federal Law.

F. **Conversion Privilege**. A Domestic Partner and the Eligible Dependents of a Domestic Partner are eligible for the Conversion Privilege of the Contract.

SECTION 3
MEDICAL CHILD SUPPORT ORDERS

3.1 Definitions

A. **Medical Child Support Order** means an "order" issued in the format prescribed by federal law; and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An "order" means a judgment, decree or a ruling (including approval of a settlement agreement) that:

1. is issued by a court or administrative child support enforcement agency of any state or the District of Columbia; and

2. Creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage; or establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

B. **Qualified Medical Support Order ("QMSO")** means a Medical Child Support Order issued under State law, or the laws of the District of Columbia, and when issued to an employer sponsored health plan.

3.2 Eligibility and Termination.

A. Upon receipt of a QMSO, when coverage of the Subscriber's family members is available under the terms of the Subscriber's contract then CareFirst will accept enrollment regardless of enrollment period restrictions. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any State or the District of Columbia. If the Subscriber has not completed any applicable waiting periods for coverage, the child will not be enrolled until the end of the waiting period.

The Subscriber must be enrolled under this contract in order for the child to be enrolled. If the Subscriber is not enrolled when CareFirst receives the QMSO, CareFirst will enroll both the Subscriber and the child, without regard to enrollment period restrictions.

B. Enrollment for such a child will not be denied because the child:

1. Was born out of wedlock.

2. Is not claimed as a dependent on the Subscriber's federal tax return.

3. Does not reside with the Subscriber.

4. Is covered under any Medical Assistance or Medicaid program.

C. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to a QMSO may not be terminated unless written evidence is provided to CareFirst that:

1. The QMSO is no longer in effect;

2. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of

coverage; or,

3. If coverage is provided under an employer sponsored health plan;

    a. The employer has eliminated family member coverage for all employees; or

    b. The employer no longer employs the Subscriber, except if the Subscriber elects continuation under applicable State or federal law the child will continue in this post-employment coverage.

3.3 Administration. When the child subject to a QMSO does not reside with the Subscriber, CareFirst will:

A. Send the non-insuring custodial parent ID cards, claim forms, the applicable certificate of coverage or member contract and any information needed to obtain benefits;

B. Allow the non-insuring custodial parent or a provider of a covered service to submit a claim without the approval of the Subscriber;

C. Provide benefits directly to:

1. The non-insuring parent;

2. The provider of the covered services; or

3. The appropriate child support enforcement agency of any State or the District of Columbia.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Member Coverage by CareFirst.

A. CareFirst can terminate coverage if CareFirst determines:

1. The Member allowed another person to use his/her identification card or the Member used another person's identification card. The identification card must be returned to CareFirst upon request.

2. The Member made an intentional misrepresentation of information which was material to the acceptance of the application when the Member represented that all information contained in the Enrollment Application was true, correct and complete to the best of the Member's knowledge and belief.

3. The Member made an intentional misrepresentation of any information required by CareFirst on any forms or other written requests for data. Such information will include but not be limited to requests for medical information, coordination of benefits information, subrogation information, employment status and dependent eligibility status.

4. The Member or the Member's representative made fraudulent misstatements related to coverage or benefits under the Contract.

4.2 Termination of Coverage by the Employee/Member.

A. The Employee/Member can remove an eligible Dependent if the Employee/Member makes a written request to the Group, at least 31 days prior to the requested termination date.

B. CareFirst shall not be required to give notice of termination to the Employee/Member or Dependents as a result of the Employee/Member's written request for termination.

C. Except as otherwise provided all Employee/Member benefits under the Contract will end as stated below.

a. Coverage for all Members under this Contract will terminate on as determined by the Employee/Members Office of Human Resources.

b. Coverage for all Members under this Contract will terminate as determined by the Employee/Members Office of Human Resources.

1. If the Subscriber remains eligible for coverage under this Contract, but another Member's eligibility ceases:

a. Coverage under this Contract will terminate as determined by the Employee/Members Office of Human Resources.

b. Coverage for a Dependent Child will terminate as determined by the Employee/Members Office of Human Resources.

c. Coverage for a Student Dependent will terminate as determined by the Employee/Members Office of Human Resources.

d. Coverage for a Student Dependent will terminate as determined by the

Employee/Members Office of Human Resources.

4.3 Loss of Eligibility as a Dependent. Coverage of Dependents will automatically terminate when the Dependent reaches the Limiting Age or there is a change in the Dependent's status or relationship to the Employee/Member such that the Dependent no longer meets the eligibility requirements of the Contract. Termination of Coverage of Dependents due to loss of eligibility will be effective as stated in Section 2, Eligibility and Enrollment.

A. It is the Employee/Member's responsibility to notify the Group, and the Group's responsibility to notify CareFirst, of any changes in the status of his/her Dependents that affect their eligibility for coverage under the Contract.

B. If the Employee/Member does not notify the Group, and the Group does not notify CareFirst, and it is later determined that a Dependent was not eligible for coverage, CareFirst has the right to recover the full value of the services and benefits provided during the period of ineligibility. CareFirst can recover these amounts from the Employee/Member or from the Dependent, at CareFirst's option.

4.4 Death of an Employee/Member. In the event of the Employee/Member's death, coverage of any Dependents will continue, under a newly assigned identification, as determined by the Employee/Members Office of Human Resources.

4.5 Reinstatement Requires Application. If coverage of any Member is cancelled or terminated for any reason, coverage may be renewed only if the individual reestablishes eligibility and submits an application in accordance with Section 2, Eligibility and Enrollment. Coverage will not reinstate automatically, under any circumstances.

4.6 Continuation of Coverage under COBRA. This provision applies if the group plan is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time (COBRA) and the Members coverage terminates due to a "Qualifying Event" as described under COBRA. A Member may elect to continue the Member's coverage under the Group Contract to the extent and for the time period permitted by COBRA. The Sponsor of the group plan is the Plan Administrator. It is the Plan Administrator's responsibility to notify the Member whether COBRA applies and, if so, the terms, conditions and rights that apply to the Member under COBRA. The Member should contact the Plan Administrator if the Member has any questions regarding the Member's rights under COBRA.

4.7 Extension of Benefits for the Point-of-Service (In-Network benefits only) Program Option. If a Member is confined in an institution in which benefits are covered under this Contract on the date this Contract terminates (unless termination is due to failure to pay a premium when otherwise eligible to do so), CareFirst will continue to provide the benefits described in this Contract, until the earliest of the following:

A. The date the confinement ceases;

B. The date the Member is no longer, in the judgment of CareFirst's Medical Director, or his or her designee, medically required to continue care as an inpatient; or

C. 90 days following termination.

4.8 Extension of Benefits for the Point-of-Service (Out-of-Network benefits only) Program Option.

A. If a Member is Totally Disabled when his/her coverage terminates, CareFirst shall

continue to pay covered benefits, in accordance with the Evidence of Coverage in effect at the time the Member's coverage terminates, for expenses incurred by the Member for the condition causing the disability until the earlier of:

1. The date the Member ceases to be Totally Disabled; or

2. 12 months after the date coverage terminates.

Same Age Group means within the age group including persons three years older and younger than the age of the person claiming eligibility as Totally Disabled.

Substantial Gainful Activity means the undertaking of any significant physical or mental activity that is done (or intended) for pay or profit.

Totally Disabled (or Total Disability) means a condition of physical or mental incapacity of such severity that an individual, considering age, education, and work experience, cannot engage in any kind of Substantial Gainful Activity or engage in the normal activities as a person of the Same Age Group. A physical or mental incapacity is an incapacity that results from anatomical, physiological, or psychological abnormality or condition, which is demonstrable by medically accepted clinical and laboratory diagnostic techniques. CareFirst reserves the right to determine whether a Member is and continues to be Totally Disabled.

B. If a Member is confined in a hospital on the date that the Member's coverage terminates, CareFirst shall continue to pay covered benefits, in accordance with the Evidence of Coverage in effect at the time the Member's coverage terminates, for the confinement until the earlier of:

1. The date the Member is discharged from the hospital; or

2. 12 months after the date coverage terminates.

If the Member is Totally Disabled upon his/her discharge from the hospital, the extension of benefits described in paragraph A., above applies; however, an additional 12-month extension of benefits is not provided. An individual is entitled to only one 12-month extension, not an inpatient 12-month extension and an additional Totally Disabled 12-month extension.

C. This section does not apply if:

1. Coverage is terminated because an individual fails to pay a required Premium;

2. Coverage is terminated for fraud or material misrepresentation by the individual.

4.9 Conversion Privilege. Members whose coverage under the Contract terminates may be eligible for conversion coverage. Eligibility for conversion coverage is described in Section 5 of this Program Description.

SECTION 5
CONVERSION PRIVILEGE

5.1 Conversion Privilege.

A. **Group Conversion**. All Members covered under the Contract whose coverage is terminated for any reason except those listed in Section 5.1.B below are eligible to apply for a Conversion Contract. The Member must apply within 31 days of the termination date.

B. **When Conversion Coverage Is Not Provided**. A Member is not eligible for a conversion contract if the Member:

1. Is eligible for or covered by Medicare;

2. Is eligible for or covered by substantially the same level of hospital, medical, and surgical benefits under state or federal law;

3. Is covered by substantially the same level of hospital, medical, and surgical benefits under any policy, contract, or plan for individuals or groups;

4. Has not been continuously covered during the 3 month period immediately preceding the terminating event; or,

5. Was terminated from the Contract for:

   a. Failure to pay the premium or Copayments;

   b. Fraud or deception in the use of services or facilities;

   c. Violation of the terms of the prior contract; or,

   d. For other good cause as specified in the Contract.

5.2 Application for Conversion Contracts. A Member who is entitled to continue coverage through a Conversion Contract should contact CareFirst as soon as possible after coverage terminates to request an application form and a schedule of premiums. Benefits under a Conversion Contract may vary from the benefits under the Contract and CareFirst reserves all rights, subject to applicable requirements of law, to determine the form and terms of the Conversion Contract(s) to be issued.

A. CareFirst must receive a completed application from the Member, including full payment of the first premium, within 31 days after the effective date of termination.

B. Conversion Contracts issued under this Section will not require evidence of insurability.

C. In no case will enrollment be denied based on the health status of the Member; or, for exercising complaint and grievance rights under the Contract.

5.3 Effective Date of Conversion Contract. A Conversion Contract issued under this Section will be effective on the day following the date the Contract terminated or the Member's coverage under the Contract terminated.

SECTION 6
MULTIPLE COVERAGE

6.1 Coordination Of Benefits ("COB").

A. **Applicability**

1. This Coordination of Benefits ("COB") provision applies to CareFirst when a Member has health care coverage under more than one Plan. " Plan " and "CareFirst" are defined below.

2. If this COB provision applies, the Order Of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of CareFirst are determined before or after those of another Plan.

The benefits for CareFirst:

a. Shall not be reduced when, under the order of determination rules, CareFirst determines its benefits before another Plan; but

b. May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is described in the "Effect on Benefits" Section below.

B. **Terms.** For the purpose of this COB Section, the following terms are defined. The definitions of other capitalized terms are found in the Definitions Section of This Certificate.

1. **Plan**: any health insurance policy, including those of nonprofit health service Plan's, and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim.

The term Plan includes coverage under a governmental Plan, or coverage required or provided by law. This does not include a State Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

The term Plan does not include:

a. an individually underwritten and issued, guaranteed renewable, specified disease policy;

b. an intensive care policy, which does not provide benefits on an expense incurred basis;

c. coverage regulated by a motor vehicle reparation law;

d. the first $100 per day of a Hospital indemnity contract; or,

e. an elementary and or secondary school insurance program sponsored by a school or school system.

An "intensive care policy" means a health insurance policy that provides benefits only when treatment is received in that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

A "specific disease policy" means a health insurance policy that provides (1) benefits only for a disease or diseases specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

2. **CareFirst**: Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield.

3. **Primary Plan Or Secondary Plan**: the order of benefit determination rules state whether CareFirst is a Primary Plan or Secondary Plan as to another Plan covering the Member.

   When CareFirst is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When CareFirst is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the Member, this CareFirst may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expenses**: a health care service or expense, including deductibles, coinsurance or copayments, that is covered at least in part by any of the Plans covering the Member, except as set forth below. This means that an expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense. When a Plan provides benefits in the form of services, (for example an HMO or a Closed Panel Plan) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

5. **Claim Determination Period**: A calendar year unless a different benefit year basis is specifically stated in the Schedule of Benefits. However, it does not include any part of a year during which a Member has no coverage under CareFirst, or any part of a year before the date this COB provision or a similar provision takes effect.

6. **Closed Panel Plan** means a Plan that provides health benefits to Member*s* primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

C. **Order Of Determination Rules**

1. **General**. When there is a basis for a claim under CareFirst and another Plan, CareFirst is a Secondary Plan which has its benefits determined after those of

the other Plan, unless;

a. The other Plan has rules coordinating benefits with those of CareFirst; and

b. Both those rules and CareFirst rules, in subsection 2. below, require that CareFirst benefits be determined before those of the other Plan.

2. **Rules**. CareFirst determines its order of benefits using the first of the following rules which applies:

a. Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

1) Secondary to the Plan covering the person as a dependent, and

2) Primary to the Plan covering the person as other than a dependent (e.g. retired employee),

Then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

b. Dependent child/parents not separated or divorced. Except as stated in paragraph 2.c, below, when CareFirst and another Plan cover the same child as a dependent of different persons, called "parents:"

1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

2) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in 1) immediately above, but instead has a rule based upon the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. Dependent child/parents separated or divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1) First, the Plan of the parent with custody of the child;

2) Then, the Plan of the spouse of the parent with the custody of the child; and

3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child follow the order of benefit determination rules outlined in paragraph 2.b.

e. Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule e. is ignored.

f. Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to Federal or State law also is covered under another Plan, the following shall be the order of benefits determination:

1) First, the benefits of a Plan covering the person as an employee, member or Subscriber (or as that person's dependent);

2) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

g. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter term.

D. **Effect on Benefits**

1. **When this Section applies**. This Section applies when, in accordance with the prior Section, order of benefits determination rules, CareFirst is a Secondary Plan as to one or more other Plans. In that event the benefits of CareFirst may be reduced under this Section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

2. **Reduction in CareFirst's Benefits**. The benefits under CareFirst will be reduced when the sum of:

   a. the benefits that would be payable for the Allowable Expense under CareFirst in the absence of this COB provision; and

   b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of CareFirst will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

   When the benefits of CareFirst are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of CareFirst.

E. **Right To Receive And Release Needed Information**

Certain facts are needed to apply these COB rules. CareFirst has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst need not tell, or get the consent of, any person to do this. Each person claiming benefits under CareFirst must give CareFirst any facts it needs to pay the claim.

F. **Facility Of Payment**

A payment made under another Plan may include an amount, which should have been paid under CareFirst. If it does, CareFirst may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under CareFirst. CareFirst will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

G. **Right Of Recovery**. If the amount of the payments made by CareFirst is more that it should have paid under this COB provision, it may recover the excess from one or more of:

   1. the persons it has paid or for whom it has paid;

   2. insurance companies; or,

   3. other organizations.

   The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2 **Medicare Eligibility**. This provision applies to Members who are enrolled in Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of 65 or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in the evidence of coverage. Benefits that are covered by Medicare are subject to the provisions in this Part.

A. **Coverage Secondary to Medicare**. Except where prohibited by law, the benefits under CareFirst plan are secondary to Medicare.

B. **Medicare as Primary**.

1. When benefits for Covered Services are paid by Medicare as primary, CareFirst will not duplicate those payments. When CareFirst coordinates the benefits with Medicare, CareFirst payments will be based on the Medicare allowance (if the provider is a participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare).

2. Benefits under CareFirst will be coordinated as described above to the extent a benefit would have been provided or payable under Medicare if the Member had diligently sought to establish his or her right to such benefits. Members shall agree to complete and submit to Medicare, CareFirst and/or Contracting Providers all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

6.3 Employer or Governmental Benefits.

Coverage under CareFirst does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a "Benefit" (as defined below) is provided or is required to be provided either:

A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or

B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, but excluding Medicare benefits and Medicaid benefits.

Benefit defined. As used in this provision, "benefit" includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

6.4 Subrogation.

Subrogation applies when a Member has an illness or injury for which a third party may be liable. Subrogation requires the Member in certain circumstances to turn over to CareFirst any rights the Member may have against a third party.

A. The Member shall notify CareFirst as soon as reasonably possible and no later than the time the Member provides proof of a claim that a third party may be liable for the injuries or illnesses for which benefits are being paid.

B. To the extent that benefits are paid under this Contract, CareFirst shall be subrogated and succeed to any right of recovery of the Member against any person or organization.

C. The Member shall pay to CareFirst the amount recovered by suit, settlement, or otherwise from any third party or third party's insurer, or uninsured or underinsured motorist coverage, to the extent of the benefits paid under this Contract.

6.5 Personal Injury Protection ("PIP") Coverage.

PIP is insurance coverage without regard to fault provided under a Member’s motor vehicle casualty insurance.

CareFirst will not reduce, limit, or exclude coverage due to payments made to the Member under the Member's PIP Policy.

SECTION 7
APPEALS AND GREIVANCE

CareFirst's appeal procedure is designed to enable you to have your concerns regarding a denial of benefits or authorization for services heard and resolved. By following the steps outlined below, you can ensure that your appeal is quickly and responsively addressed.

An expedited appeal process has been established in the event that a delay in a decision would be detrimental to your health or the health of a covered family member. In an expedited appeal, a decision by CareFirst shall be made within 24 hours, and review will be done by a peer of the patient's treating healthcare provider, if additional information would not change the Plan's decision. Expedited Appeals involve care that has not yet occurred or is currently occurring. (Pre Service or concurrent care).

Step 1: Discussion of the Problem

Your concerns can often be handled and resolved through informal discussions and information gathering. If your question relates to our handling of a claim or other administrative action, call and discuss the matter with a CareFirst member services representative. In many instances, the matter can be quickly resolved.

Step 2: Appeal/ Grievance Process

If your concern is not resolved through a discussion with a CareFirst representative, you or someone on your behalf may make a formal request for appeal. CareFirst must receive the request within 180 days or six months of the date of the notification of denial of benefits or services. If the request for appeal is related to a medical issue, a peer of the patient's treating health care provider, not part of the original denial decision, will review the request. This request should be in writing and addressed to the Member Services Department, and shall state the reason of the request. A Member Services representative will be available to assist you in submitting your appeal in the event you are unable to put the request in writing. All appeal decisions will be rendered in writing to the member, and include a detailed explanation as to the reason for the decision, and any supporting documentation to show how that decision was made. Included in this written appeal decision will be an explanation of the appropriate next steps a member may take if they are not satisfied with the appeal decision.

SECTION 8
GENERAL PROVISIONS

8.1 No Assignment. A Member cannot assign any benefits or payments due under the Contract to any person, corporation or other organization, except as required by law.

8.2 Payments Under the Contract. Payments for covered services will be made by CareFirst directly to Participating Providers. If a Member receives covered services from Non-Participating Providers, CareFirst reserves the right to pay either the Member or the provider and such payment shall, in either case, constitute full and complete satisfaction of CareFirst's obligation.

8.3 Claim Payments Made in Error. The Member is liable for any amount paid to a Member by CareFirst by mistake or in error on behalf of a Member.

8.4 Time Period for Filing Claims. All claims for covered services and supplies must be submitted to CareFirst or its designee within the timely filing periods that are listed below.

All medical claims being files under the In-Network portion of the Point-of-Service Program Option must be submitted within ninety (90) days after the date the services were rendered or supplies were received. The Member is only responsible for filing claims for urgent or emergency care services that were provided by an Out-of-Network Provider. In this instance, the Member is also responsible for providing information requested by CareFirst, including medical records.

All claims being filed under the Out-of-Network portion of the Point-of-Service Program Option must be submitted within fifteen (15) months after the date the services were rendered or supplies were received.

CareFirst or its designee will only consider claims beyond the filing period if the Member becomes legally incapacitated prior to the end of the filing period.

8.5 Member Statements. Except in the instance of fraud, all statements made by Members shall be considered representations and not warranties and no such statement shall be the basis for avoiding coverage or denying a claim after coverage has been in force for two years from its Effective Date, unless the statement was material to the risk and was contained in a written application.

8.6 Identification Card. Any cards issued to Members are for identification only.

A. Possession of an identification card confers no right to benefits under the Contract.

B. To be entitled to such benefits under the Contract, the holder of the card must, in fact, be a Member on whose behalf all applicable charges have actually been paid.

C. Any person receiving benefits to which he or she is not then entitled under the Contract will be liable for the actual cost of such benefits.

8.7 Member Medical Records. It may be necessary to obtain Member medical records and information from hospitals, skilled nursing facilities, physicians or other practitioners who treat the Member. When a Member becomes covered under the Contract, the Member (and if the Member is legally incapable of giving such consent, the representative of such Member) automatically gives CareFirst permission to obtain and use such records and information, including medical records and information requested to assist CareFirst in determining benefits and eligibility of Members.

8.8 Privacy Statement. CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable medical or health-related data. In that regard, CareFirst will not provide to the plan sponsor named herein or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.

8.9 CareFirst's Relationship to the Group. The Group is not an agent or representative of CareFirst and is not liable for any acts or omissions by CareFirst or any Participating Provider. CareFirst is not an agent or representative of the Group and is not liable for any act or omission of the Group.

8.10 Administration of the Contract. CareFirst may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Contract.

8.11 Rights under Federal Law. The Contract may be subject to federal law including the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") and/or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Group is the "Plan Administrator" for the purposes of ERISA and/or COBRA. As the Plan Administrator, it is the Group's responsibility to provide the Member with certain information, including access to, and copies of, plan documents describing benefits and rights to coverage under the Group health plan. Such rights include the right to continue coverage upon the occurrence of certain "qualifying events." Under HIPAA, Certificates of Creditable Coverage will be provided by CareFirst. In any event, the Member should check with the Group to determine their rights under ERISA, COBRA, and/or HIPAA, as applicable.

8.12 Rules for Determining Dates and Times. The following rules will be used when determining dates and times under the Contract:

A. All dates and times of day will be based on Eastern Standard Time or Eastern Daylight Saving Time, as applicable.

B. When reference is made to coverage being effective on a particular date, this means 12:01 a.m. on that date.

C. When reference is made to termination being effective on a particular date, this means 12:00 midnight on that date.

D. "Days" mean calendar days, including weekends, holidays, etc, unless otherwise noted.

E. "Year" refers to calendar year, unless a different basis is specifically stated.

8.13 Notices to the Subscriber. Notices to Subscribers required under the Contract shall be in writing directed to the Subscriber's last known address. It is the Group's responsibility to notify CareFirst of a Subscriber address change. The notice will be effective on the date mailed, whether or not the Subscriber receives the notice or there is a delay in receiving the notice.

8.14 Contract Binding on Members. The Contract can be amended, modified or terminated in accordance with any provision of the Contract or by mutual agreement between CareFirst and the Group. This does not require the consent or concurrence of Members. By electing coverage under the Contract, or accepting benefits under the Contract, each Member agrees (and if the Member is legally incapable of contracting, the representative of such Member agrees) to all the terms, conditions and provisions of the Contract.

8.15 Provider and Services Information. Listings of current In-Network Providers will be made available to Member's at the time of enrollment. Updated listings are available upon request.

8.16 Events outside of CareFirst's Control.

A. An event outside of the control of CareFirst refers to a natural disaster, epidemic, complete or partial destruction of facilities, disability of a significant part of CareFirst or BlueChoice Provider staff, war (whether declared or not), riot, civil insurrection or any similar event over which CareFirst cannot exercise influence or control.

B. When an event outside the control of CareFirst affects the operations of CareFirst or MPOS and BlueChoice Providers, CareFirst and MPOS or BlueChoice Providers will use their best efforts to continue to provide and arrange benefits and services to Members under the Contract, taking into account the impact of the event on facilities an personnel and the extent to which the services required by the Member are Medically Necessary and urgently needed.

C. If CareFirst and MPOS or BlueChoice Providers are unable to provide or arrange benefits in a reasonable manner and within a reasonable time of the Member's request, coverage will be provided for covered services obtained from any physician, hospital or provider of the Member's choice. The Member or the provider will be reimbursed for the cost of such services up to the benefit limits of the Contract if, and to the extent, CareFirst determines:

1. That the services would have been covered under the Contract if provided or arranged by a MPOS and BlueChoice Provider;

2. That obtaining these services from a MPOS or BlueChoice Provider was impossible, impractical or would have entailed a medically unacceptable delay; and

3. That the services were Medically Necessary and urgently needed.

D. Except as provided in Sections B and C above, neither CareFirst nor any MPOS or BlueChoice Provider will have any liability or obligation for delay or failure to provide or arrange any services or benefits when the delay or failure is caused by an event outside CareFirst's control.

8.17 Relationship to Maryland Point-of-Service (MPOS) and BlueChoice Physicians and Other MPOS and BlueChoice Providers. MPOS and BlueChoice Physicians and MPOS and BlueChoice Providers are independent contractors or organizations and are related to CareFirst by contract only. MPOS and BlueChoice Physicians and MPOS and BlueChoice Providers are not employees or agents of CareFirst and are not authorized to act on behalf of or obligate CareFirst with regard to interpretation of the terms of the Contract, including eligibility of Members for coverage or entitlement to benefits. MPOS and BlueChoice Physicians maintain a physician-patient relationship with the Member and are solely responsible for the professional services they provide. CareFirst is not responsible for any acts or omissions, including those involving malpractice or wrongful death of MPOS and BlueChoice Physicians, MPOS and BlueChoice Providers or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

8.18 Certificate of Creditable Coverage. CareFirst will furnish a written certificate of creditable coverage via first-class mail.

A. Termination of CareFirst Coverage Prior to Termination of Coverage under the Group.

If a Member's coverage under this Group Contract ceases before the Member's coverage under

the Group ceases, CareFirst will provide sufficient information to the Group (or to another party designated by the Group) to enable the Group (or other party), after termination of the Member's coverage under the Group, to provide a certificate that reflects the period of coverage under this Group Contract.

B. Members for Whom Certificate Must be Provided; Timing of Issuance

1. Issuance of Automatic Certificates

a. Qualified Beneficiaries Upon A Qualifying Event

In the case of a Member entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the Member would lose coverage in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. CareFirst will provide the certificate no later than the time a notice is required to be furnished for a qualifying event relating to notices required under COBRA.

b. Other Members When Coverage Ceases

In the case of a Member who is not a qualified beneficiary entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the Member ceases to be covered under this Group Contract. CareFirst will provide the certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of Premiums).

If a Member's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease on the earliest date that a claim in denied due to the operation of the lifetime limit.

c. Qualified Beneficiaries When COBRA Ceases

In the case of a Member who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the Member became entitled to elect COBRA continuation coverage), CareFirst will provide the certificate at the time the Member's coverage under the COBRA continuation coverage ceases. CareFirst will provide the certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of Premiums). CareFirst will provide the certificate regardless of whether the Member has previously received a certificate under paragraph B.1.a of this section.

2. Any Individual Upon Request

CareFirst will provide a certificate in response to a request made by, or on behalf of, a Member at any time while the Member is covered under this Group Contract and up to 24 months after coverage ceases. CareFirst will provide the certificate by the earliest date that CareFirst, acting in a reasonable and prompt fashion, can provide the certificate. CareFirst will provide the certificate regardless of whether the Member has previously received a certificate under paragraph B.1.b., paragraph 2 or B. 1.b of this section.

3. If the Group retroactively terminates a Member beyond the period specified in the Group Contract, the Group agrees to indemnify and hold harmless CareFirst, its subsidiaries, officers, employees, agents and contractors from any and all claims, actions, damages, liabilities, and expenses whatsoever (including reasonable attorney fees) incurred or for which liability for the payment of has been determined, as a result of any act or omission on the part of the Group or its subsidiaries, officers, employees, agents and contractors in connection with or related to any failure to comply with any provisions of law, regulation or administrative directive, relating to or concerning the providing of timely and adequate Certificates of Coverage and as the same is more fully addressed and set forth under the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any future amendments thereto.

C. Combining Information For Families

A certificate may provide information with respect to both a Subscriber and Dependents if the information is identical for each Member. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each Member and separately states the information that is not identical.

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An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT A
DESCRIPTION OF COVERED SERVICES

This Attachment to the evidence of coverage describes the services eligible for coverage under CareFirst. The coverage to which Members are entitled is subject to the limitations as stated in the Schedule of Benefits. It is important to refer to the Schedule of Benefits to determine the payments CareFirst will make, the charges for which the Member will be responsible and any specific limits on the number of services that will be covered.

SECTION 1
GENERAL PROVISIONS

1.1 **Benefits Terms Defined**. In addition to the previously defined terms, this Attachment uses certain other defined terms. These are generally defined in the Section in which they first appear. The following general terms are also used:

The **Allowed Benefit** (In-Network) payable to a Plan Provider for a Covered Service will be the lesser of:

1. the provider's actual charge, which, in some cases, will be a rate set by a regulatory agency; or

2. the benefit amount, according to the CareFirst BlueChoice rate schedule for the Covered Service that applies on the date that the service is rendered.

   The benefit payment is made directly to the Plan Provider and is accepted as payment in full, except for the Copayment and Coinsurance amounts set forth in the Schedule of Benefits. The Member is responsible for any applicable Copayment and Coinsurance as set forth in the Schedule of Benefits, and the Plan Provider may bill the Member directly for such amounts.

For a non-Plan Provider, the greater of:

1. 125% of the rate the health maintenance organization pays in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider under written contract with the health maintenance organization; or,

2. The rate as of January 1, 2000 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider not under written contract with the health maintenance organization.

For a non-Plan Trauma Physician for Trauma Care rendered to a Trauma Patient in a Trauma Center, at the greater of:

1. 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; or

2. The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider.

   Benefits may be paid to the Subscriber or to the non-Plan Provider at the discretion of CareFirst BlueChoice. The Member is responsible for the non-Plan Physician or non-Plan Provider's total charge and the non-Plan Physician or non-Plan Provider may bill the Member directly.

Allowed Benefit (Out-of-Network) means:

For a Participating Provider, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment and Coinsurance amounts, for which the Member is responsible.

For a Non-Participating Practitioner, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit for a Participating Provider. The benefit is payable to the Member or to the provider, at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts and for the difference between the Allowed Benefit and the Practitioner's actual charge.

For a Non-Participating Facility, the Allowed Benefit for a Covered Service is the Facility's actual charge, which, in some cases, will be a rate set by a regulatory agency. The benefit is payable to the Member or to the Facility, at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoyer/stair lifts, ramps, shower/bath bench, items available without a prescription.

Cosmetic means the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Eligible Provider means either a Health Care Facility or a Health Care Practitioner, as these terms are defined below, licensed or otherwise authorized by law to provide health care services.

Emergency Services means those health care services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

1. Serious jeopardy to the mental or physical health of the individual; or

2. Danger of serious impairment of the individual's bodily functions; or

3. Serious dysfunction of any of the individual's bodily organs; or

4. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as CareFirst determines.

Habilitative Services means the process of educating or training persons with a disadvantage or disability caused by a medical condition or injury to improve their ability to function in society, where such ability did not exist, or was severely limited, prior to the habilitative education or training.

Health Care Facility means a Hospital, ambulatory surgical facility or center, inpatient rehabilitation facility, home health agency, skilled nursing facility, hospice facility, hospice program, urgent care center or partial hospitalization program that is licensed or certified, or both, to operate within the jurisdiction in which it is located.

Health Care Practitioner means a physician, dentist (D.D.S. or D.M.D.) or other provider of health care whose services, by law, must be covered subject to the terms of this Agreement, such as: a chiropodist, chiropractor, doctor of podiatry, doctor of surgical chiropody, nurse anesthetist, nurse midwife, nurse practitioner, optician, optometrist, physical therapist, physiotherapist, audiologist, psychologist, social worker, licensed clinical professional counselor, licensed clinical marriage and family therapist, and licensed clinical alcohol and drug counselor.

In-Network Facility means a Participating Provider which is a facility that has a written agreement with CareFirst BlueCross BlueShield to render covered services to the Member in accordance with the terms and conditions of either our National Capital Area Point-of- Service Plan or our Maryland Point-of-Service Plan. The fact that a facility in a Participating Provider does not guarantee that the facility is an In-Network Facility.

In-Network Practitioner means a Participating Provider who is a licensed Health Care Practitioner and who has a written agreement with CareFirst BlueCross BlueShield to render covered services to the Member in accordance with the terms and conditions of either our National Capital Area Point-of-Service Plan or our Maryland Point-of-Service Plan. The fact that a Health Care practitioner is a Participating Provider does not guarantee that the Health Care Practitioner is an In-Network Practitioner.

A listing of In-Network Providers will be provided to the Member when they enroll and is also available from us upon request. The listing of In-Network Providers is subject to change. The Member may confirm the status of any provider prior to making arrangements to receive care by contacting us for up-to-date information.

Network Physician means a licensed doctor who has entered into a contract with CareFirst to provide services to Members and who has been designated by CareFirst as a Network Physician.

Network Provider means any physician, health care professional or health care facility that has entered into a contract with CareFirst and has been designated by CareFirst to provide services to Members as described in the Description of Covered Services. Two Provider Networks are available through CareFirst.

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-The-Counter medications and solutions.

Participating Provider means an Eligible Provider that contracts with CareFirst to be paid directly for rendering covered services to the Member in accordance with the terms and conditions of this Plan.

Primary Care Physician ("PCP") means a designated provider within one of our Provider Networks selected by or on behalf of the Member to provide primary care to the Member and to coordinate and arrange other required services.

Provider Network means those providers who have contracted with CareFirst BlueCross BlueShield ("CareFirst") to render covered services as described in the Description of Covered Services. Two Provider Networks are available through CareFirst:

A. Providers who contract with CareFirst of Maryland, Inc. (MPOS).

B. Providers who contract with CareFirst BlueChoice, Inc. (CFBC).

Rehabilitative Services include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an Illness. The goal of Rehabilitative Services is to return the individual to his/her prior skill and functional level.

Skilled Nursing Care means Medically Necessary skilled care services performed in the home, by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN). Skilled Nursing Care services must be based on a Plan of Treatment submitted by a Health Care Provider. Skilled Nursing Care visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if visits were not provided, a Member would have to be admitted to a hospital or Skilled Nursing Facility). Services of a home health aide, medical social worker or registered dietician may also be provided but must be performed under the supervision of a licensed professional (RN or LPN) nurse.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care or Rehabilitative Services.

1.2 Benefits Under the Point-of-Service Plan. The Point-of-Service Plan offers two levels of benefits. The Member may select the benefit level at which coverage will be provided each time care is sought. Under the Point-of-Service Plan, the Member may receive benefits for a particular service under either the In-Network component or the Out-of-Network component. The Member may not receive duplicate benefits for the same services.

A. **In-Network Benefits**. In-Network benefits apply when covered services are provided by the Members Primary Care Physician or obtained from other In-Network Providers. In-Network benefits also apply to covered emergency services or urgent care, even if obtained from Out-of-Network Providers.

When In-Network benefits apply, the Member is eligible for a higher level of benefits than the Out-of-Network component. When the Member uses an In-Network Provider, benefits are based on the appropriate In-Network Provider Allowance. The level of benefits is reflected in the Schedule of Benefits. In-Network Providers will submit claims to us directly for covered services. The In-Network Provider will accept 100% of the In-Network Provider Allowance as full payment for covered services.

B. **Out-of-Network Benefits**. Out-of-Network benefits apply when the Member obtains covered services from a Provider who is not an In-Network Provider. When the Out-of-Network benefits apply, the Member will receive reduced benefits for covered services.

When the Member uses a provider that is not an In-Network Provider benefits are based on the appropriate Allowed Benefit. The level of Out-of-Network benefits is shown in the Schedule of Benefits. The Member may be responsible for amounts in excess of the Allowed Benefit for these services.

1. When benefits require prior approval by CareFirst BlueChoice under utilization management requirements (see Section 2) it is the Member's responsibility to ensure that an approval is obtained and to ensure that services are rendered in accordance with such approval in order to qualify for benefits.

2. Members may receive benefits for a particular episode of care under either the In-Network component or the Out-of-Network component. Members or providers may not combine In-Network and Out-of-Network benefits within the same episode of care or receive duplicate benefits for the same services.

3. If a Member's admitting physician in a non-Provider Network Provider, the entire course of treatment is considered Out-of-Network, even if the Member is admitting to a Contracting Hospital.

1.3 Open Access Feature.

Members are not required to obtain referrals in order to receive covered In-Network services from Network Providers. This provision eliminates the need for standing referrals to Network Specialists for conditions or diseases that are life threatening, degenerative, chronic, or disabling, and which require specialized medical care.

1.4 Selection of a Primary Care Physician.

A. All Members must select a PCP to receive In-Network services. A Member may choose a PCP from either of the Provider Networks. Members may also self-refer to either the Maryland Point-of-Service Network (MPOS) or the CareFirst BlueChoice Network.

B. CareFirst may require a Member to change to a different Primary Care Physician if:

1. The Member's Primary Care Physician is no longer available as a Primary Care Physician under the coverage provided by the Program; or

2. CareFirst determines that the furnishing of adequate medical care is jeopardized by a seriously impaired physician-patient relationship between the Member and Primary Care Physician, due to any of the following:

a. The Member refuses to follow a treatment procedure recommended by the Primary Care Physician and the Primary Care Physician believes that no professionally acceptable alternative exists;

b. The Member engages in threatening or abusive behavior toward the physician, the physician's staff, or other patients in the office; or

c. The Member attempts to take unauthorized controlled substances from the Primary Care Physician's office, or to obtain these substances through fraud, misrepresentation, forgery, or by altering the physician's prescription order.

3. If a change in Primary Care Physicians is required under Section 1.4.A, CareFirst will notify the Member in advance. If a change is required under Section 1.4.C, the action is effective upon written notice to the Member. If a Member is required to change to another Primary Care Physician due to any of the circumstances described in Section 1.4.C, and there is a recurrence of the same or a similar situation with another Primary Care Physician, CareFirst may terminate the Member's coverage upon 31 days written notice.

1.5 BlueCard

Like all Blue Cross and Blue Shield Licensees, CareFirst participates in a program called "BlueCard." BlueCard provides Members with an extended network of Participating Providers for out-of-area care. Members participating in BlueCard are responsible for ensuring out-of-area care is rendered by Participating. Whenever Members access health care services outside the geographic area CareFirst serves, the claim for those services may be processed through BlueCard and presented to CareFirst for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Members receive covered health care services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), CareFirst will remain responsible to the Montgomery County Government for fulfilling CareFirst's contractual obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers.

The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim

The calculation of the Members liability on claims for covered health care services Incurred outside the geographic area CareFirst serves and processed through BlueCard will be based on the lower of the Health Care Provider's billed charges or the negotiated price CareFirst pays the Host Blue.

The calculation of the Montgomery County Government's liability on claims for covered health care services Incurred outside the geographic area CareFirst serves and processed through BlueCard will be based on the negotiated price CareFirst pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Health Care Provider contracts. The negotiated price paid to a Host Blue by CareFirst on a claim for health care services processed through BlueCard may represent:

1. The actual price paid on the claim by the Host Blue to the Health Care Provider ("Actual Price"), or

2. An estimated price, determined by the Host Blue in accordance with BlueCard Policies,

based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's Health Care Providers or one or more particular Health Care Providers ("Estimated Price"), or

3. An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Health Care Providers or for a specified group of Health Care Providers ("Average Price"). An Average Price may result in greater variation to the Member and Montgomery County Government from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Member and Montgomery County Government is a final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of Estimated Price or Average Price may result in some portion of the amount paid by Montgomery County Government being held in a variance account by the Host Blue, pending settlement with its participating Health Care Providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to Montgomery County Government and are eventually exhausted by Health Care Provider settlements and through prospective adjustments to the negotiated prices.

Statutes in a small number of states may require a Host Blue either:

1. To use a basis for calculating the Members liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim, or

2. To add a surcharge.

When Members receive Covered Services in these states, the Members' and Montgomery County Government's liability for Covered Services will be calculated using these states' statutory methods. However, when this payment methodology results in a conflict of statutes or regulations between two states, CareFirst will comply with the statutes of the jurisdiction in which Montgomery County Government 's Contract was issued.

Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from participating Health Care Providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Health Care Provider audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require either correction on a claim-by-claim basis or on a prospective basis through an allocated reduction on future claims where recoveries cannot be linked to specific claims.

CareFirst will arrange to share such recoveries proportionately with Montgomery County Government and Members in accordance with the terms and conditions of Montgomery County Government's Contract.

BlueCard Fees and Compensation

Montgomery County Government understands and agrees:

1. To pay certain fees and compensation to CareFirst which CareFirst is obligated under BlueCard to pay to the Host Blue, to the Blue Cross and Blue Shield Association, or to BlueCard vendors, unless CareFirst's contractual obligations with Montgomery County Government require those fees and compensation to be paid only by CareFirst and

2. That fees and compensation under BlueCard may be revised from time to time without the Montgomery County Government's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard.

Some of these fees and compensation are charged each time a claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Also, some of these claim-based fees, such as the access fee and the administrative expense allowance fee may be passed on to Montgomery County Government as an additional claim liability. Other fees include, but are not limited to, an 800 number fee and a fee for providing PPO Health Care Provider directories, if applicable. If Montgomery County Government does not have a complete listing, or wants an updated listing, of these types of fees or the amount of these fees paid directly by Montgomery County Government should contact its CareFirst representative.

Utilization Management Requirements and BlueCard

The Utilization Management Requirements of the Contract, if any, shall apply to BlueCard. The Member is responsible for:

1. Ensuring all Utilization Management Requirements are followed;

2. Any penalties for not complying with such requirements; and, or

3. Charges for out-of-area care CareFirst deems not Medically Necessary; and/or not covered under the Contract.

However, there may be instances where BlueCard claims are subject to the Host Blue's utilization management requirements and/or provider network rules, which may vary slightly from those stated in the Contract. Such variances may result from state laws that differ from those in the jurisdiction in which Montgomery County Government's Contract was issued or from contracts the Host Blue holds with its vendors/providers.

While CareFirst strives to provide consistent benefits for all Members, another plan's utilization management requirements/vendors and provider network rules may sometimes affect a Member's benefits. Members accessing health care services outside the geographic area CareFirst serves should call 1-800-810-BLUE (2583) for that plan's utilization management requirements/provider network rules.

BlueCard Program Applicability

The BlueCard Program does not apply to Dental Care Benefits; Prescription Drug Benefits; Vision Care Benefits.

1.6 Overview of Cost Sharing and Maximum Amounts. This Section summarizes the cost sharing and maximum amounts of this benefit program. Detailed information about these features can be found in the Schedule of Benefits including specific terms and amounts and any special exceptions.

Deductibles:	For most covered services, the Program does not begin to pay benefits until a Member meets his Deductible for that year. The Deductible will be calculated on a calendar year basis. The deductible is met when a Member receives services that are subject to the deductible and pay for them directly. Under the Members Point-of-Service Plan, there is only a deductible for Out-of-Network services. This is explained in the Schedule of Benefits. The Schedule of Benefits also provides important information about the deductible or deductibles, including the deductible amount(s), how the deductibles apply to Out-of-Network services and a listing of the services that are subject to the deductible(s).
Coinsurance:	Once the deductible is met (or for services without a deductible), benefits are based on a sharing of costs between the Member and CareFirst. For most Out-of-Network services, these costs are shared based on the percentage of expenses that we pay and the percentage that the Member must pay. These percentages are referred to as the coinsurance. Most In-Network services are not subject to coinsurance. See the Schedule of Benefits.
Copayment:	A copayment is similar to coinsurance, except that copayments are set as a fixed dollar amount, rather than as a percentage of expenses.
Out-of-Pocket Maximums:	The Out-of-Pocket maximums limit the maximum amounts that the Member will have to pay Copayments and Coinsurance in any given year. Once a Member meets the annual Copayment/Coinsurance Maximum, he or she will no longer be required to pay Copayments or a share of the Coinsurance for the remainder of that year. In addition, the out-of-pocket limits may apply to certain copayments and deductibles. Under the Point-of-Service Plan, there may be a single out-of-pocket maximum for In-Network and Out-of Network services or separate out-of-pocket maximums that apply to each. This is explained in the Schedule of Benefits. The Schedule of Benefits also provides important information about the Members out-of-pocket maximum or maximums, including, the maximum out-of-pocket amount(s), how the out-of-pocket maximums apply to In-Network and Out-of Network services and a listing of the expenses that are subject to the out-of-pocket maximums(s).
Lifetime Maximum	If the coverage has a Lifetime Maximum (this will be shown on the Schedule of Benefits), there is a cap on the total benefits that the Program will pay on behalf of any individual Member in his lifetime. If a Lifetime Maximum applies to the Member's coverage, a Member who reaches the Lifetime Maximum will thereafter have only a limited benefit, up to an “Annual Benefit Restoration Amount.” If applicable, these terms are further described in the Schedule of Benefits. Check the Schedule of Benefits.

1.7 Limitation on Provider Coverage. Services are covered only if the provider is an Eligible Provider as defined above. The provider must be licensed in the jurisdiction in which the services are rendered. In addition, to be covered the services must be within the lawful scope of the services for which that provider is licensed. Coverage does not include services rendered to the Member by any individual who:

A. Is not an Eligible Provider, as defined above.

B. Is related to the Member by blood or marriage.

C. Resides in the Members home.

1.8 Plan Benefit Payments. Except when the Member receives services under the BlueCard Program as described above, benefit payments are based on the Allowed Benefit, as determined by CareFirst, for various types of services and providers.

A. When services are rendered to a Member by a provider who is not under written contract with CareFirst, CareFirst shall pay the provider or the Member, at the discretion of CareFirst, within 30 days after receipt of the claim.

B. When services are covered under the Out-of-Network component, providers are not required to accept the Allowed Benefit as full payment and may collect additional amounts from the Member, up to the providers' full charges. The Allowed Benefit may be substantially lower than the amount actually charged to the Member. When services are covered under the Out-of-Network component, Members will generally be required to pay additional amounts to providers that exceed the Allowed Benefit.

1.9 Filing Claims.

A **In-Network**. Under Section 9, Emergency Services and Urgent Care, of Attachment A, Description of Covered Services, Members may be required to submit claims to CareFirst in order to receive benefits for qualifying Emergency Services and Urgent Care. When a Member obtains covered urgent or emergency care services from a non-Network Provider, the Member must submit a completed claim form, or have the provider submit a completed claim form, to CareFirst no later than 90 days following the date of service or, if the services were provided to the Member resulted in an inpatient admission, no later than 90 days following discharge. A claim form will be provided to the Member upon request. The Member is also responsible for providing information requested by CareFirst, including, but not limited to, medical records.

Failure to file the claim within the time required does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, if the claim is filed as soon as reasonably possible and, except in the absence of legal capacity, not later than 1 year from the time proof is otherwise required.

For In-Network services provided by Network Providers, Members are not required to submit claims in order to obtain benefits. Billing and reimbursement will be handled by CareFirst directly with Network Providers.

In all other instances, all claims for Covered Services and supplies must be submitted to CareFirst within the time frames listed below:

1. If the claim for Covered Services and/or supplies is submitted by a Network Provider, within the time frame provided in the contract between CareFirst and the provider;

2. If the claim for Covered Services and/or supplies is submitted by a non-Network Provider, within the time frame granted to the Member to file a claim;

B. **Out-of-Network**.

1. **Member Responsibility to File Claims.** When services are covered under the Out-of-Network component, Members are required to submit claims or have claims filed by their provider in order to receive benefits.

2. **Claim Forms**. A Member may request a claim form by writing or calling CareFirst. CareFirst does not require a written notice of a claim. The Plan, upon receipt of a notice of claim, will send the Member claim forms. If claim forms are not sent within fifteen (15) days after receipt of the notice of claim by CareFirst , CareFirst shall consider the Member to have complied with the requirements of the evidence of coverage as to proof of loss upon submitting, within the time stated in the evidence of coverage for filing proof of loss, written proof of the occurrence, character and the extent of the loss for which a claim is made. Benefits will be paid within thirty (30) days after receipt of written proof of loss.

3. **Time in which to File Claims**. When a Member obtains Covered Services under the Out-of-Network component, the Member must submit a completed claim form, or have the provider submit a completed claim form, to CareFirst within fifteen (15) months after the date the services were rendered or supplies were received. If the services were provided to the Member as a result of an inpatient admission, no later than 180 days following discharge. A claim form will be provided to the Member upon request. The Member is also responsible for providing information requested by CareFirst, including but not limited to, medical records.

Failure to file the claim within the time required does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, if the claim is filed as soon as reasonably possible and, except in the absence of legal capacity, not later than 1 year from the time proof is otherwise required.

In all other instances, if a claim for Covered Services and/or supplies is submitted by a non-Provider Network Provider, the claim must be submitted within the time frame granted to the Member to file a claim.

SECTION 2
UTILIZATION MANAGEMENT REQUIREMENTS

IMPORTANT

FAILURE TO MEET THE REQUIREMENTS OF THE UTILIZATION MANAGEMENT PROGRAM MAY RESULT IN A REDUCTION OR DENIAL OF COVERAGE EVEN IF THE SERVICES ARE OTHERWISE MEDICALLY NECESSARY.

2.1 Utilization Management. Before certain services will be covered (See Section 2.5 below), they will be subject to review and approval under Utilization Management Requirements established by the Program. Through Utilization Management, CareFirst reviews a Member's care and evaluates requests for approval of coverage to assess the Medical Necessity for the services, the appropriateness of the Hospital or facility requested, and the appropriate length of confinement or course of treatment. This assessment will be made in accordance with established criteria. In addition, Utilization Management may include and/or pre-admission testing requirements, concurrent review, discharge planning and Case Management. Failure or refusals of the Member to comply with notice requirements and other Utilization Management authorization and approval procedures will result in the denial of, or a significant reduction in, benefits. The effect on coverage for failure to comply with Utilization Management Requirements is explained in the Schedule of Benefits. If coverage is reduced or denied for failure to comply with Utilization Management Requirements, the reduction or exclusion will be applied to all services related to the treatment, admission, or portion of the admission for which Utilization Management Requirements were not met.

2.2 Provider's Responsibility. Providers are responsible for providing Utilization Management notices and obtaining necessary Utilization Management approvals on the Member's behalf for certain types of services and/or episodes of care. These are designated in the Schedule of Benefits. For these services, Members will not be responsible for notification and approvals. However, the Member must advise the Provider of the Program that he or she is eligible under. In addition, Members must comply with Utilization Management Requirements and determinations. If the Member refuses to follow these requirements, coverage will be reduced or excluded. **In all other instances, it is the Member's responsibility to comply with the Utilization Management Requirements described in Section 2.5, below.**

2.3 Member Responsibility. Except as provided in Section 2.2 above, Members are responsible for all Utilization Management Requirements. It is the Member's responsibility to assure that Hospitals, physicians, and other providers associated with the Member's care cooperate with Utilization Management Requirements. This includes initial notification in a timely manner, responding to CareFirst's inquiries and, if requested, allowing CareFirst representatives to review medical records on-site or in its offices. If CareFirst is unable to conduct utilization reviews, benefits may be reduced or denied.

2.4 Procedures. To initiate Utilization Management review, a Member may directly contact CareFirst or may arrange to have notification given by a family member or by the physician, provider, or facility that is involved in the Member's care. These individuals will be deemed to be acting on the Member's behalf. If the Member and/or the Member's representatives fail to contact CareFirst as required, or if they provide inaccurate or incomplete information, the Member will be responsible for any reduction or exclusion of benefits.

CareFirst will provide additional information regarding Utilization Management Requirements and procedures, including telephone numbers and hours of operation, at the time of enrollment or at any time upon the Member's request. For questions regarding Utilization Management Requirements, please call the toll- free number for pre-certification on the back of the Member's ID card.

2.5 Services Subject to Utilization Management. Except as provided in Section 2.2 above, the Member must satisfy the Utilization Management Requirements to qualify for coverage for the following services:

a. **Hospital Inpatient Services**. All hospitalizations require pre-certification (except for maternity). A Member must contact CareFirst (or have his physician or the Hospital contact CareFirst) at least five (5) business days prior to an elective or scheduled admission to the Hospital. If the admission cannot be scheduled in advance because it is not medically feasible to delay the admission for five (5) business days due to a medical condition, CareFirst must receive notification of the admission as soon as possible but, in any event, within 48 hours following the beginning of the admission, or the end of the first business day following the beginning of the admission, whichever is later.

b. **Inpatient Mental Health and Substance Abuse Services**. All hospitalizations for Mental Health and Substance Abuse services require pre-certification. A Member must contact CareFirst or its designee (or have his physician or the Hospital contact CareFirst or its designee) at least five (5) business days prior to an elective or scheduled admission to the Hospital. If the admission cannot be scheduled in advance because it is not medically feasible to delay the admission for five (5) business days due to a medical condition, CareFirst must receive notification of the admission as soon as possible but, in any event, within 48 hours following the beginning of the admission, or the end of the first business day following the beginning of the admission, whichever is later.

c. **Outpatient Mental Health and Substance Abuse Services**. CareFirst or its designee will review and evaluate claims for Outpatient Mental Health and Substance Abuse services to assess the medical necessity and appropriateness of the services. CareFirst will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment.

d. **Other Services**. If a Member requires any of the following services, the Member must contact CareFirst (or have the Member's physician, Hospital, or other provider facility contact CareFirst) at least five (5) business days prior to the anticipated date upon which the elective admission or treatment will commence:

- Medical Devices & Supplies
- Home Health Care Services
- Skilled Nursing Facility Services
- Hospice Care Services
- Outpatient Private Duty Nursing;
- Treatment of Infertility, limited to:
  - Artificial Insemination (AI);
  - Intrauterine Insemination (IUI);
  - Assisted Reproductive Technology, including:
    * In-Vitro Fertilization (IVF);
    * Gamete Intra-fallopian Transfer (GIFT);
    * Zygote Intra-fallopian Transfer (ZIFT).

CareFirst reserves the right to make changes to the categories of services that are subject to Utilization Management Requirements or to the procedures Members and/or providers must follow. CareFirst will notify the Group or Member of such changes.

2.6 Concurrent Review and Discharge Planning. Following timely notification as described above, CareFirst will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of approved treatment.

2.7 Case Management. This is a feature of this health benefit plan for a Member with a chronic condition, a serious illness, or complex health care needs. CareFirst will initiate and perform Case Management services, as deemed appropriate by CareFirst, which may include the following:

a. Assessment of individual/family needs related to the understanding of health status and physician treatment plans, self-care and compliance capability, and continuum of care;

b. Education of individual/family regarding disease, treatment compliance and self-care techniques;

c. Help with organization of care, including arranging for needed services and supplies;

d. Assistance in arranging for a principal or Primary Care Physician to deliver and coordinate the Member's care, and/or consultation with physician specialists; and

e. Referral of Member to community resources.

2.8 Appealing a Utilization Management Decision. If a Member or Member's provider disagrees with a Utilization Management decision, the decision will be reviewed upon request. If necessary, the Medical Director or Associate Medical Director will discuss the Member's case with the Member's physician. Any non-certification or penalty may be appealed. Please refer to the Appeals and Grievance procedures (Section 7, Program Description) .

SECTION 3
OUTPATIENT AND OFFICE SERVICES

3.1 **Covered Outpatient Medical Services**. Members are entitled to benefits for the Covered Services listed below when provided by In-Network Providers or Out-of-Network in accordance with the requirements of the Contract.

A. Office visits, medical care, urgent care, surgery and consultations, with a PCP and other In- Network Providers or Out-of-Network Providers. This includes a history and baseline examination after enrollment.

B. Diagnostic Procedures.

C. Laboratory Tests and X-ray Services rendered by designated In-Network Providers or Out-of-Network, whether ordered by a Provider Network Provider or a non-Provider Network Provider.

D. Cancer Screening. Benefits are provided for cancer screening, including:

1. Prostate-specific antigen (PSA) tests and digital rectal exams are covered:

a) For men who are between 40 and 75 years of age;

b) When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;

c) When used for staging in determining the need for a bone scan for patients with prostate cancer; or,

d) When used for male Members who are at high risk for prostate cancer.

2. Pap smears, at intervals appropriate to the Member's age and health status, as determined by CareFirst.

3. Mammography services, at intervals described in the Schedule of Benefits.

4. Colorectal cancer screening. Benefits are available for colorectal cancer screening in accordance with the most current guidelines issued by the American Cancer Society.

E. Health Exams. Health exams and other services for the prevention and detection of disease, at intervals appropriate to age, sex and health status as determined by CareFirst. These services are not covered if required solely for:

1. Employment;

2. Insurance;

3. Travel;

4. School;

5. Camp admissions; or

6. Participation in sports activities.

F. Immunizations. Coverage is provided in accordance with accepted medical practice. Immunizations required solely for travel are not covered.

G. Allergy Testing and Treatment. Benefits include allergy testing and treatment, including administration of injections and allergy sera.

H. Obstetric and Gynecological Care.

A Member who is pregnant may self refer to a Provider Network Provider obstetrician-gynecologist. Thereafter, the obstetrician-gynecologist may assume responsibility for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with the Plan's policies and procedures, through the postpartum period.

A female Member may receive Medically Necessary and routine obstetric and gynecological care from a Provider Network Provider who is a certified nurse midwife or other health care practitioner authorized under state law to provide obstetric and gynecological services without a referral from her Primary Care Physician.

A certified nurse midwife or other health care practitioner shall consult with an obstetrician/gynecologist with whom the certified nurse midwife or other health care practitioner has a collaborative agreement, in accordance with the collaborative agreement, regarding any care rendered for the Member under this paragraph.

I. Well Child Preventive Care and pediatric services in accordance with the most recent guidelines of the American Academy of Pediatrics.

J. Eye Examinations. Eye examinations for the diagnosis and treatment of a medical condition. Annual routine eye examinations and eye refraction via self-referral to a Provider Network Provider optometrist or vision center or to a Provider Network Provider ophthalmologist.

K. Rehabilitation Services. Coverage shall include Occupational Therapy, Physical Therapy and Speech Therapy as defined below subject to any limitations as stated in the Schedule of Benefits.

1. Definitions.

a. Occupational Therapy (OT) means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition. Occupational therapy services do not include the adjustment or manipulation of any of the osseous structures of the body or spine.

b. Speech Therapy (ST) means the treatment of communication impairment and swallowing disorders. Speech therapy services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation, including

cognitive rehabilitation.

c. Physical Therapy (PT) means the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

2. Covered physical therapy, speech therapy, or occupational therapy services are not subject to utilization management requirements, if treatment is received from a Network Provider.

L. Radiation Therapy.

M. Chemotherapy.

N. Family Planning Services. Coverage includes but is not limited to:

1. Contraceptive counseling;

2. Depo-Provera, Norplant, intra-uterine devices and any Medically Necessary insertion, removal, or examination associated with the use of any contraceptive drug or device that is approved by the FDA for use as a contraceptive.

O. Renal Dialysis (Hemodialysis and Peritoneal dialysis for Chronic Kidney Conditions). Coverage will be provided for Medically Necessary services including equipment, training and Medical Supplies, required for home dialysis.

1. Benefits will not be provided for any furniture, plumbing, electrical or other fixtures, Convenience Items or for professional assistance needed to perform the dialysis treatment in the home.

2. If it is determined that a Member no longer meets the criteria for Medical Necessity, CareFirst's obligation is limited to paying for services up to the date that determination is communicated to the Member.

P. Blood and Blood Products.

1. Administration of infusions and transfusions.

2. Blood and blood products (including derivatives and components) that are not replaced by or on behalf of the Member.

Q. Spinal Manipulation Services.

1. Limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.

2. Covered spinal manipulation services are not subject to referral or utilization

management requirements, if treatment is received from a Network Provider.

R. Human Papillomavirus Screening Test.

1. Coverage is provided for a human papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.

2. Human Papillomavirus Screening Test means any laboratory test that specifically detects for infection by one or more agents of the human papillomavirus and is approved for this purpose by the FDA.

3.2 Outpatient Surgical Care. Benefits are available for the following services in a Hospital or in an ambulatory surgical facility, in connection with a covered surgical procedure. Services provided to the Member as an outpatient in a Hospital must receive prior authorization from CareFirst.

A. Use of operating room and recovery room.

B. Use of special procedure rooms.

C. Anesthesia services and supplies.

D. Diagnostic procedures, laboratory tests and x-ray services.

E. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

F. Medical and surgical supplies.

G. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administrations of infusions are covered.

H. Coverage will be available for the following surgical procedures performed by Health Care Practitioners on an outpatient basis subject to the applicable Utilization Management Requirements (Section 2).

1. Pre- and post-operative services are included in the Allowed Benefit. There are no separate benefits except as specified in this contract.

2. If multiple surgical procedures are performed during the same operative session, CareFirst will review the procedures to determine the benefits provided:

a. if the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the contract based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.

b. if the additional procedures are not clinically integral to the primary procedure, including, but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the

contract based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.

3.3 **Coverage for Infertility Services**. Benefits are provided for infertility services including artificial insemination and in-vitro fertilization, when the Member is married or in a Domestic Partnership.

A. Benefits are limited to:

1. Infertility counseling;

2. Testing;

3. Assisted reproductive technologies as described and limited below.

B. Artificial insemination.

1. Benefits are available when:

a. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of at least 1 year of unprotected vaginal intercourse following the reversal of an elective sterilization procedure in order for artificial insemination to be covered.

b. The Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination; and

c. The treatment is pre-authorized by CareFirst.

2. Any charges associated with the collection of sperm will not be covered unless the male donor is also a Member.

3. The Member is responsible for the copayment as stated in the Schedule of Benefits.

C. In-vitro fertilization (IVF).

1. Benefits (including zygote and gamete intra-fallopian transfer) are provided for outpatient expense arising from IVF procedures approved by the federal Food and Drug Administration that are performed at medical facilities that conform to:

a. The American College of Obstetricians and Gynecologists guidelines for IVF clinics; or,

b. The American Society for Reproductive Medicine minimal standards for IVF programs.

2. Benefits are available when:

a. The treatment is pre-authorized by CareFirst;

b. The oocytes (eggs) are physically produced by the Member and fertilized

with sperm;

c. The Member has been unsuccessful through less costly infertility treatment for which coverage is available; and

d. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of infertility of at least 2 years' duration; or, the infertility is associated with any of the following medical conditions:

i. Endometriosis;

ii. Exposure in utero to diethylstilbestrol, commonly known as DES.

iii. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); however, if blockage is due to an elective sterilization procedure, the Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must also have a history of infertility of at least 2 years' duration following the reversal of an elective sterilization procedure.

iv. Abnormal male factors, including oligospermia, contributing to the infertility.

3. Benefits, are limited to:

a. A lifetime maximum payment as stated in the Schedule of Benefits.

b. Three attempts per live birth.

The lifetime maximum and benefit limits in no way create a right to benefits after termination of the Member's coverage under the evidence of coverage.

4. The Member will be responsible for the coinsurance as stated in the Schedule of Benefits.

D. When the Member has had a reversal of an elective male or female surgical sterilization procedure then:

1. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of infertility of at least 2 years' duration following the reversal of an elective sterilization procedure in order for IVF procedures to be covered.

2. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of at least 1 year of unprotected vaginal intercourse following the reversal of an elective sterilization procedure in order for artificial insemination to be covered.

E. Exclusions. Specific exclusions related to infertility services are listed with the Exclusions at the end of this Description Of Covered Services.

3.4 Organ and Tissue Transplants.

A. Benefits for organ and tissue transplants are limited to the following procedures:

1. Kidney; cornea; bone; skin (for grafting or for any other medically necessary purposes);

2. Heart; combined heart and lung; single lung; double lung; pancreas, when performed simultaneously with a kidney transplant; liver. Prior to commencing a course of treatment for these procedures, a Member must obtain CareFirst's written approval for both the procedure and the facility where the transplant will be done. No benefits will be provided for the facility, the procedure, or any resulting complication if the Member did not receive advance written approval.

3. Autologous bone marrow or stem cell transplants that are not Experimental/ Investigational as determined by CareFirst; and

4. Allogeneic bone marrow or stem cell transplants that are not Experimental/ Investigational as determined by CareFirst.

B. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant. The cost of these drugs will not be counted towards any prescription drug benefit maximum under any endorsements and/or riders attached to the evidence of coverage.

C. Donor services are covered to the extent that they are not covered under any other health insurance plan or by any other source such as research funds or medical service grants. Donor benefits are provided for services that are related to the surgery. Coverage is provided for evaluating and preparing an actual donor and related recovery services after the donor procedures, regardless of whether the transplant is attempted or completed. Donor registry charges are covered.

D. Cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of 18 years) to and from the site of the transplant if approved by CareFirst. This benefit is available only when the covered transplant is not performed in the Service Area.

E. Additional organ and tissue transplant benefits other than those listed above are not covered unless the Group has purchased a rider or endorsement attached to the evidence of coverage providing for expanded organ and tissue transplant coverage.

F. Exclusions. Specific exclusions related to organ transplants are listed with the Exclusions at the end of this Description Of Covered Services.

3.5 High Dose Chemotherapy/ Bone Marrow or Stem Cell Transplant. Benefits will be provided for high dose chemotherapy bone marrow or stem cell transplant treatment that is not Experimental/Investigational as determined by CareFirst.

3.6 Patient Costs for Clinical Trials. Benefits for Patient Cost to a Member in a Clinical Trial will be provided in accordance with the terms below. All services must be pre-authorized or pre-approved by CareFirst.

A. Terms.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes:

1. The National Cancer Institute Clinical Cooperative Group;

2. The National Cancer Institute Community Clinical Oncology Program;

3. The Aids Clinical Trials Group; and,

4. The Community Programs For Clinical Research In Aids.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary service that is incurred as a result of the treatment being provided under the Clinical Trial. Patient Cost does not include:

1. The cost of an Experimental-Investigative drug or device;

2. The cost of non-health care services that a Member may be required to receive under the Clinical Trial;

3. Costs associated with managing the research associated with the Clinical Trial; or

4. Costs that would not be covered under the evidence of coverage for non-Investigative treatments.

B. Patient Cost related to a Clinical Trial will be covered if the Member's participation in the Clinical Trial is the result of:

1. Treatment studies provided for a life-threatening condition; or

2. Prevention, early detection, and treatment studies on cancer.

C. Coverage for Patient Cost for treatment being provided will be evaluated on a case-by-case basis. Coverage for Patient Cost will be provided only if:

1. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for treatment, prevention and early detection of cancer; or

2. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for treatment, prevention and early detection of any other life threatening condition;

3. The treatment is being provided in a Clinical Trial approved by:

a. One of the National Institutes of Health, such as the National Cancer Institute (NCI); or

b. An NIH Cooperative Group or an NIH Center; or

c. The FDA in the form of an Experimental-Investigative new drug application; or

d. The federal Department of Veterans Affairs; or,

e. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office Of Protection From Research Risks of the NIH;

4. The facility and personnel providing the treatment are capable of doing so by virtue of their:

a. Experience;

b. Training; and,

c. Volume of patients treated to maintain expertise;

5. There is no clearly superior, non-Investigative treatment alternative; and,

6. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Investigative alternative.

D. Coverage is provided for Patient Cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

3.7 Maternity Benefits.

A. Maternity Services. Benefits are provided for all female Members including:

1. Obstetrical care, prenatal, delivery, postnatal care;

2. Coverage for a Hospital stay;

3. Coverage for care rendered by a CareFirst approved licensed birthing center;

4. Collection of adequate samples for hereditary and metabolic newborn screening and follow-up;

5. Medically Necessary services for the normal newborn (an infant born at approximately 40 weeks gestation who has no congenital or comorbid conditions including but not limited to neonatal jaundice) including the admission history and physical, and discharge examination;

6. Medically Necessary inpatient/outpatient Health Care Provider services for a newborn with congenital or comorbid conditions; and

7. Newborn hearing screening prior to discharge.

B. Postpartum Home Visits. Home visits following delivery are covered in accordance with the most current standards published by the American College of Obstetricians and Gynecologists.

1. For a mother and newborn child who have a shorter hospital stay than that provided under Section 2.2.D, Number of Hospital Days Covered, benefits will be provided for:

a. one home visit scheduled to occur within 24 hours after hospital discharge; and

b. an additional home visit if prescribed by the attending provider

2. For a mother and newborn child who remain in the hospital for at least the length of time provided under Section 2.2.D, Number of Hospital Days Covered, benefits will be provided for a home visit if prescribed by the attending provider

C. Birthing Classes. Birthing classes are covered, one course, per pregnancy at a CareFirst approved facility.

3.8 Morbid Obesity.

A. Benefits are available for the surgical treatment of Morbid Obesity. The procedures must be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity and are consistent with guidelines approved by the National Institutes of Health.

B. Morbid Obesity means a body mass index that is:

1. Greater than 40 kilograms per meter squared; or

2. Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

C. As used above, body mass index (BMI) means a practical marker used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

3.9 Diabetic Supplies and Services.

A. Coverage will be provided for Medically Necessary diabetes equipment; diabetes supplies; and diabetes outpatient self-management training and educational services, including medical nutritional counseling at a CareFirst approved facility.

B. The services must be Medically Necessary as determined by CareFirst for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

C. In-person, outpatient self-management training and educational services, including medical nutritional therapy, shall be provided through an in-person program provided by an appropriately licensed, registered, or certified CareFirst-approved facility or health care provider whose scope of practice includes diabetes education or management.

3.10 Dental Services.

A. Accidental Injury. Benefits include Medically Necessary, as determined by CareFirst, dental services needed as a result of an accidental bodily injury (except for accidents caused by chewing) when the Member requests treatment within 60 days of the accident.

B. General Anesthesia for Dental Care. Benefits for Medically Necessary general anesthesia in conjunction with dental care and associated hospital or ambulatory facility charges will be provided to a Member when determined by a licensed dentist in consultation with the Member's treating physician to effectively and safely provide dental care:

1. If the Member is:

   a. Seven years of age or younger;

   b. Developmentally or otherwise severely disabled; and

   c. For whom a successful result cannot be expected under local anesthesia because of the physical, intellectual or other medically compromising condition of the Member.

2. Or, if the Member is:

   a. Seventeen years of age or younger;

   b. An extremely uncooperative, fearful, or uncommunicative individual;

   c. An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and

   d. An individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

3. A determination of medical necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition requires general anesthesia and the admission to a hospital or outpatient surgery facility in order to safely provide the dental care.

4. Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:

   a. A fully accredited specialist in pediatric dentistry;

   b. A fully accredited specialist in oral and maxillofacial surgery; and

   c. A dentist to whom hospital privileges have been granted.

5. Benefits for the general anesthesia and associated hospital or ambulatory facility charges require prior approval by CareFirst. The Member or provider of service must contact CareFirst prior to the date that services are rendered to obtain approval.

6. Benefits are not provided for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporal mandibular joint disorders.

7. Benefits for the underlying dental care are not covered.

3.11 **Oral Surgery**. Benefits include:

A. Medically Necessary procedures, as determined by CareFirst, to attain functional capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or exostoses, or drain abscesses with cellulitis and are performed on sound natural teeth and supporting structures, lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, and jaws.

B. Medically Necessary procedures, as determined by CareFirst, needed as a result of an accidental injury, when the Member requests oral surgical services or the need for oral surgical services is identified in the patient's medical records within 60 days of the accident. Benefits for such oral surgical services shall be provided up to three (3) years from the date of injury.

C. Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness.

D. All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for Cosmetic purposes or for correction of the malocclusion are excluded.

E. Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a Member's condition, benefits will be based upon the lowest cost alternative.

3.12 **Reconstructive Breast Surgery**. Benefits will be provided for reconstructive breast surgery resulting from a Mastectomy performed as a result of breast cancer. Mastectomy means the surgical removal of all or part of a breast as a result of breast cancer.

A. Reconstructive Breast Surgery includes:

1. Augmentation mammoplasty;

2. Reduction mammoplasty; and

3. Mastopexy.

B. Benefits are provided for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery on the diseased breast is performed.

C. Benefits are provided regardless of whether the Mastectomy was performed while the

Member was covered under the evidence of coverage.

D. Coverage will be provided for prostheses for a Member who has undergone a Mastectomy as well as services resulting from physical complications at all stages of Mastectomy including lymphedema.

3.13 **Reconstructive Surgery**. Benefits for reconstructive surgery are limited to surgical procedures that are Medically Necessary, as determined by CareFirst and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma or previous therapeutic intervention.

3.14 **Hair Prosthesis**. Subject to limitations, if any, set forth in the Schedule of Benefits, benefits for a hair prosthesis are provided when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.

3.15 **Coverage for Habilitative Services for Children**.

Occupational Therapy, Physical Therapy and Speech Therapy for the treatment of a Dependent child under the age of 19 years with a congenital or genetic birth defect that enhance the Dependent child's ability to function. This includes a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defects include, but are not limited to: autism or an autism spectrum disorder and cerebral palsy.

3.16 **Chlamydia Screening Test**.

A. Chlamydia Screening Test means any laboratory test that

1. Specifically detects for infection by one or more agents of chlamydia trachomatis; and

2. Is approved for this purpose by the Federal Food and Drug Administration.

B. Multiple Risk Factors means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

C. Coverage will be provided for an annual routine Chlamydia Screening Test for women who are under the age of 20 years if they are sexually active and 20 years old or older if they have Multiple Risk Factors.

D. Coverage will be provided for an annual routine Chlamydia Screening test for men who have Multiple Risk Factors.

E. Annual routine Chlamydia Screening Test will be subject to the same copayment as similar situated services.

3.17 **Osteoporosis Prevention and Treatment Services**.

A. Benefits are available for Bone Mass Measurement for the prevention, diagnosis, and treatment of Osteoporosis when the Bone Mass Measurement is requested by a Health Care Provider for the Qualified Individual.

B. Bone Mass Measurement means a radiologic or radioisotopic procedure or other scientifically proven technology performed on a Qualified Individual for the purpose of

identifying bone mass or detecting bone loss.

C. Qualified Individual means:

1. An estrogen deficient individual at clinical risk for osteoporosis;

2. An individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;

3. An individual receiving long-term glucocorticoid steroid therapy;

4. An individual with primary hyperparathyroidism; or

5. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

3.18 **Treatment for Cleft Lip or Cleft Palate or Both**. Benefits will be provided for inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological and speech/language for cleft lip or cleft palate or both.

3.19 **Hearing Aid for Minor Children**.

Covered Services for a minor Dependent child:

A. One Hearing Aid, prescribed, fitted and dispensed by a licensed audiologist for each hearing-impaired ear;

B. Non-routine services related to the dispensing of a covered Hearing Aid, such as assessment, fitting, orientation, conformity and evaluation.

3.20 **Coverage for Inherited Metabolic Disease**. Benefits will be provided for medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical foods and low protein modified food products are:

A. Prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases; and
B. Administered under the direction of a physician.

3.21 **Outpatient Private Duty Nursing**.

Outpatient Private Duty Nursing is defined as skilled care services, ordered by a physician, that can only be provided by a licensed health care professional who is a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), based on a treatment plan that specifically defines the skilled services to be provided as well as the time and duration of the proposed services. If the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same, then skilled care from an R.N. or an L.P.N. is not necessary. Skilled care excludes services for performing the Activities of Daily Living (ADL) including but not limited to bathing, feeding and toileting.

Conditions for Coverage:

A. The Outpatient Private Duty Nursing services must be Medically Necessary and meet the definition above;

B. The Outpatient Private Duty Nursing services must be preauthorized by CareFirst and be part of an approved treatment plan on file at CareFirst;

C. The Private Duty Nursing services must be ordered by a physician.

SECTION 4
INPATIENT HOSPITAL SERVICES

HOSPITAL ADMISSIONS MUST BE AUTHORIZED OR APPROVED BY CAREFIRST

4.1 **Covered Inpatient Hospital Services**. A Member will receive benefits for services listed below when admitted to a Provider Network or Non-Provider Network hospital. Coverage of inpatient hospital services is subject to certification by Utilization Management for Medical Necessity. Benefits are provided for:

A. Room and Board. Room and board in a semiprivate room (or in a private room when Medically Necessary as determined by CareFirst).

B. Physician and Medical Services. Inpatient physician and medical services provided by or under the direction of the attending Contracting Physician, including:

1. Inpatient Contracting Physician visits.

2. Consultations by Contracting Physician Specialists.

3. Intensive care services.

4. Rehabilitation Services.

5. Respiratory therapy, radiation therapy and chemotherapy services.

6. Anesthesia services and supplies.

7. Diagnostic procedures, laboratory tests and x-ray services.

8. Medically Necessary Ancillary Services rendered to the Member.

9. Surgical Care. Coverage will be available for the following surgical procedures performed by Health Care Practitioners or during a covered inpatient Hospital admission for which benefits are being provided under Section 4, subject to the applicable Utilization Management Requirements (Section 2).

a. Pre- and post-operative services are included in the Allowed Benefit. There are no separate benefits except as specified in this contract.

b. If multiple surgical procedures are performed during the same operative session, CareFirst will review the procedures to determine the benefits provided:

1) if the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the contract based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.

2) if the additional procedures are not clinically integral to the

primary procedure, including, but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the contract based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.

C. Services and Supplies. Related inpatient services and supplies that are not Experimental/Investigational, as determined by CareFirst, and ordinarily furnished by the Hospital to its patients, including:

1. The use of:

   a. Operating rooms;

   b. Treatment rooms; and

   c. Special equipment in the Hospital.

2. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

3. Medical and surgical supplies.

4. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administrations of infusions are covered.

5. Surgically implanted Prosthetic devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants and pacemakers. Available benefits under this provision do not include items such as artificial limbs or eyes, hearing aids, or other external prosthetics, which may be provided under other provisions of the evidence of coverage. See Section 10, Medical Devices, below and Section 3.19, Hearing Aids for Minor Children and Section 3.12, Reconstructive Breast Surgery, above.

6. Medical social services.

4.2 **Number of Hospital Days Covered**. Provided the conditions, including the requirements in Section 4.3 below are met and continue to be met, as determined by CareFirst, benefits for Inpatient Hospital Services will be provided as follows:

A. Hospitalization for Rehabilitation. Benefits are provided for an admission or transfer to CareFirst approved facility for rehabilitation. Benefits provided during any confinement will not exceed the benefit limitation, if any, stated in the Schedule of Benefits. As used in this paragraph, a confinement means a continuous period of hospitalization or two or more admissions separated by 30 days. This limit on hospitalization applies to any portion of an admission that:

1. Is required primarily for Physical Therapy or other rehabilitative care; and

2. Would not be Medically Necessary based solely on the Member's need for inpatient acute care services other than for rehabilitation.

B. Inpatient Coverage Following a Mastectomy. Coverage will be provided for a minimum Hospital stay of not less than:

1. Forty-eight (48) hours following a radical or modified radical Mastectomy; and

2. Twenty-four (24) hours following a partial Mastectomy with lymph node dissection for the treatment of breast cancer.

C. Hysterectomies. Coverage will be provided for vaginal hysterectomies and abdominal hysterectomies. Coverage includes a minimum stay in the Hospital of:

1. Not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy; and

2. Not less than forty-eight (48) hours for a vaginal hysterectomy.

In consultation with the Provider Network Provider, the Member may elect to stay less than the minimum prescribed above when appropriate.

D. Childbirth. Coverage will be provided for a minimum hospital stay of not less than:

1. Forty-eight (48) hours for both the mother and newborn following a routine vaginal delivery;

2. Ninety-six (96) hours for both the mother and newborn following a routine cesarean section.

Prior authorization is not required for the minimum hospital stays listed above.

Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, coverage includes additional hospitalization for the newborn for up to four (4) days.

If the delivery occurs in the Hospital the length of stay begins at the time of the delivery. If the delivery occurs outside of the Hospital the length of stay begins upon admission to the Hospital. The Member and provider may agree to an early discharge.

E. Other Hospitalization. Hospitalization for Covered Services other than those described above, will also be provided subject to the provisions of Section 4.3, below.

4.3 Inpatient Hospital Pre-Admission Review. Coverage of inpatient hospital services is subject to the requirements for pre-admission review, concurrent review and discharge planning for all covered hospitalizations. Such review and approval shall determine:

A. The need for hospitalization;

B. The appropriateness of the approved Hospital or facility requested;

C. The approved length of confinement in accordance with CareFirst-established criteria; and

D. Additional aspects such as second surgical opinion and/or pre-admission testing requirements.

E. Failure or refusal to comply with notice requirements and other CareFirst authorization and approval procedures may result in reduction of the Members benefits or exclusion of services from coverage.

Payment for Ancillary Services may not be denied solely based on the fact that the denial of the hospitalization day was appropriate. Instead a denial of inpatient Ancillary Services must be based on the Medical Necessity of the specific Ancillary Service. In determining the Medical Necessity of an Ancillary Service performed on a denied hospitalization day, consideration must be given to the necessity of providing the Ancillary Service in the acute setting for each day in question.

SECTION 5
SKILLED NURSING FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST

5.1 **Covered Skilled Nursing Facility Services**. When the Member meets the conditions for coverage listed below in Section 5.2, the services listed below are available to Members in a Skilled Nursing Facility:

A. Room and board in a semiprivate room.

B. Inpatient physician and medical services provided by or under the direction of the attending Contracting Physician.

C. Services and supplies that are not Experimental/Investigational as determined by CareFirst and ordinarily furnished by the facility to inpatients for diagnosis or treatment, including:

1. Use of special equipment in the facility.

2. Drugs, medications, solutions, biological preparations, and Medical Supplies used while the Member is an inpatient in the facility.

5.2 **Conditions for Coverage**. Skilled Nursing Facility care must be authorized or approved by CareFirst as meeting the following conditions for coverage:

A. Skilled Nursing Facility means a licensed facility that is accredited or approved under:

1. Medicare; or

2. The Joint Commission on Accreditation of Healthcare Organizations.

B. The admission to the Skilled Nursing Facility must be a substitute for a Hospital admission. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.

C. The Member requires Skilled Nursing Care or skilled rehabilitation services that are required on a daily basis and can only be provided on an inpatient basis. Skilled Nursing Care means non-Custodial Care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

5.3 **Custodial Care Is Not Provided**. Benefits will not be provided for any day in a Skilled Nursing Facility that CareFirst determines is primarily for Custodial Care.

A. Custodial Care means care that is:

1. Not directed to the cure of an illness or recovery from an accident; and

2. Mainly for meeting the activities of daily living, e.g. bathing, eating; and

3. Not routinely provided by a trained medical professional; and

4. May be provided by person without professional medical skills or professional medical training.

B. Services may be deemed Custodial Care even if:

1. A Member cannot self-administer the care;

2. No one in the Member's household can perform the services;

3. Ordered by a physician;

4. Necessary to maintain the Member's present condition; or

5. Covered by Medicare.

5.4 **Number of Days of Care**. Benefits will be provided up to the maximum day limit, if any stated in the Schedule of Benefits.

SECTION 6
HOME HEALTH SERVICES

HOME HEALTH SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST

6.1 **Covered Home Health Services**. Services must be provided within the Service Area when requested by a PCP or other physician. Benefits are provided for:

A. Part-time or intermittent home nursing care by or under the supervision of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.).

B. Rehabilitation services.

C. Part-time or intermittent home health aid services.

D. Drugs and medications directly administered to the patient during a covered home health visit and incidental Medical Supplies directly expended in the course of a covered home health visit. Drugs, medications and medical supplies for home use (other than as described above) and purchase or rental of durable medical equipment are not covered under this Section. (See Section 8, Medical Devices. Benefits for self-administered prescription drugs may be available through a rider or endorsement purchased by the Group and attached to the evidence of coverage.)

E. Diagnostic Tests and Laboratory Services ordered by the PCP or other physician.

F. Services of a medical social worker.

6.2 **Conditions for Coverage**. Benefits are provided when a Member:

A. Is under the care of the PCP or other physician.

B. Resides within the Service Area.

C. Is confined to home due to a medical condition.

D. Would otherwise be eligible for a Hospital, or Skilled Nursing Facility admission.

E. Requires skilled nursing care or rehabilitation services in order to qualify for home health aide services or other types of home health care.

Skilled nursing care means non-Custodial Care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

F. The Medical Necessity of home health services must be certified by CareFirst as meeting the criteria for coverage.

G. The need for home health services must not be custodial in nature.

6.3 **Number of Home Health Visits**.

A. Home Health Visits Following Mastectomy or Surgical Removal of a Testicle. For a Member who receives less than 48 hours of inpatient hospitalization following a

mastectomy or the surgical removal of a testicle, or who undergoes a mastectomy or the surgical removal of a testicle on an outpatient basis, benefits will be provided for::

1. One home visit scheduled to occur within twenty-four (24) hours after discharge from the Hospital or outpatient health care facility; and

2. An additional home visit if prescribed by the Member's attending physician.

B. All other Home Health Visits will be provided up to the maximum visit limit, if any, stated in the Schedule of Benefits.

SECTION 7
HOSPICE CARE SERVICES

HOSPICE CARE SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST

7.1 **Covered Hospice Care Services**. Services are covered when provided by a Qualified Hospice Care Program. CareFirst will monitor the care for ongoing appropriateness. Benefits are provided for inpatient and outpatient care and include the following.

A. Intermittent nursing care by or under the direction of a registered nurse.

B. Medical social services for the terminally ill patient and his or her Immediate Family. Immediate Family means the patient's spouse, parents, siblings, grandparents, and children.

C. Counseling, including dietary counseling, for the terminally ill Member.

D. Non-Custodial home health visits.

E. Services, visits, medical/surgical equipment or supplies; including equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member.

F. Laboratory Tests and X-Ray Services.

G. Ambulance services, when Medically Necessary as determined by CareFirst.

H. Respite Care will be limited to 14 days per Hospice Eligibility Period. “Respite Care” means temporary care provided to the terminally ill Member to relieve the Family Caregiver from the daily care of the Member.

I. Home visits within the Service Area.

J. Inpatient care is limited to a lifetime maximum of 30 days..

K. Family Counseling will be provided for the Immediate Family and Family Caregiver before the death of the terminally ill Member when authorized or approved by CareFirst. Family Counseling means counseling given to the Immediate Family or Family Caregiver of the terminally ill Member for the purpose of learning to care for the Member and to adjust to the death of the Member. Family Caregiver means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill Member.

L. Bereavement Services will be provided for the Immediate Family or Family Caregiver of the Member for the 6-month period following the Member’s death or fifteen (15) visits, whichever occurs first. Bereavement Counseling means counseling provided to the Immediate Family or Family Caregiver of the Member after the member’s death to help the Immediate Family or Family Caregiver cope with the Member’s death.

7.2 **Conditions for Coverage**. Hospice Care Services must meet the following conditions:

A. The Member must have a life expectancy of six (6) months or less.

B. The Member's attending PCP or other referring physician must submit a written Hospice Care Services plan of treatment to CareFirst.

C. The Member must meet the criteria of the Qualified Hospice Care Program. A Qualified Hospice Care Program means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement to

1. Individuals who have no reasonable prospect of cure as estimated by a physician; and

2. The immediate families or family caregivers of those individuals.

D. The Medical Necessity and continued appropriateness of Hospice Care Services must be authorized or approved by CareFirst as meeting the criteria for coverage.

7.3 **Hospice Eligibility Period** means the period of time that begins on the first date hospice services are rendered and will terminate one hundred eighty (180) days later or on the death of the terminally ill Member, whichever first occurs. Any extension of the Hospice Eligibility Period must be authorized or approved by CareFirst. If CareFirst determines, based on grounds of Medical Necessity, that the benefit eligibility period should be extended, eligibility will be continued for up to thirty (30) additional days of outpatient services or fourteen (14) additional days of inpatient care.

SECTION 8
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

HOSPITALIZATION MUST BE AUTHORIZED OR APPROVED BY THE MENTAL HEALTH AND SUBSTANCE ABUSE MANAGEMENT PROGRAM

8.1 Definitions.

A. The Mental Health Management and Substance Abuse Program refers to utilization management, benefits administration and provider network activities administered by or on behalf of CareFirst to ensure that mental health and substance abuse services are Medically Necessary and provided in a cost-effective manner.

B. Qualified Substance Abuse Treatment Facility means a non-residential facility or distinct part of a facility which is licensed in the jurisdiction(s) in which it operates and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a substance abuse and alcohol treatment facility that operates a program for the treatment and rehabilitation of alcohol and substance abuse.

C. Partial Hospitalization means the provision of medically directed intensive or intermediate short-term treatment for mental illness, emotional disorders, drug abuse or alcohol abuse for a period of less than 24 hours but more than 4 hours in a day for a member or subscriber in a licensed or certified facility or program..

D. Substance Abuse means:

1. Alcohol Abuse means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or

2. Drug Abuse means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

8.2 Outpatient Mental Health and Substance Abuse Services. Outpatient services must be obtained from Provider Network Providers upon referral from the Mental Health and Substance Abuse Management Program. Coverage of Partial Hospitalization is subject to certification under the Mental Health Management Program of the need for treatment in a Partial Hospitalization program and the duration of such treatment.

A. Coverage is provided for outpatient services to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse including psychological and neuropsychological testing for psychological diagnostic purposes.

B. Medication management visits in connection with mental illness, emotional disorders, alcohol abuse or drug abuse will be covered in the same manner as medication management visits for physical illnesses and will not be counted as outpatient mental health or substance abuse treatment visits.

C. Coverage of substance abuse and related mental health conditions include detoxification and rehabilitative services in a CareFirst designated program.

D. Other covered medical and medical ancillary services will be covered for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

E. Coverage for Partial Hospitalization is subject to a maximum day limit as stated in the Schedule of Benefits.

8.3 **Inpatient Mental Health and Substance Abuse Services**. Covered services include the following:

A. Services for care and treatment of mental illness, emotional disorders, alcohol abuse or drug abuse, which, in the judgment of CareFirst, are Medically Necessary and treatable through inpatient hospitalization. Inpatient care is not covered if, in CareFirst's judgment, the condition and/or the treatment to be provided does not meet the criteria established by CareFirst for admission to a hospital. Hospitalization in a specialized facility that is not a CareFirst approved facility is not covered.

B. Diagnosis and treatment for the abuse of or addiction to alcohol and drugs, including inpatient detoxification and rehabilitative services in an acute care hospital or Qualified Substance Abuse Treatment Facility. A Member must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by CareFirst.

C. Visits to the patient in the hospital or facility by Contracting Physicians and Provider Network Providers are not to exceed one visit per day for each day that inpatient mental health and/or substance abuse benefits are being provided under the preceding paragraphs. For purposes of determining the number of covered inpatient professional visits utilized and the copayments applicable to such services, a visit as used in Section 6 means an inpatient consultation or group or individual session that does not exceed one hour.

D. Other covered medical and medical ancillary services will be covered for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

8.4 **Residential Crisis Center Services.** Benefits are provided for Medically Necessary residential crisis services. These services must be preauthorized. The Member or Provider should obtain approval prior to services being rendered.

A. Residential crisis services are intensive mental health and support services that must be:

1. Provided to a child or an adult Member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the Member's ability to function in the community;

2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;

3. Provided outside of the Member's residence on a short-term basis in a community-based residential setting; and,

4. Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.

B. Any coinsurance, or copayment due under the evidence of coverage for facility charges, professional services and office visits will be applied to these services, as applicable. See the Schedule of Benefits.

SECTION 9
EMERGENCY SERVICES AND URGENT CARE

9.1 Definitions.

A. Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the hospital emergency room. An Urgent Care facility is a free-standing facility that is not a physician's office and which provides Urgent Care.

B. Emergency means care provided after the sudden and unexpected onset of a medical condition of sufficient severity, including severe pain, when the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

1. Jeopardy to the mental or physical health;

2. Impairment of bodily functions;

3. Dysfunction of any bodily organs; or

4. Jeopardy to the health of a fetus.

9.2 Emergency Services and Urgent Care.

A. Benefits are available to a Member for Emergency Services and Urgent Care twenty-four (24) hours per day regardless of whether rendered inside or outside of the Service Area.

If a Member requires care while traveling or temporarily residing outside the Service Area, the Member must follow the emergency procedures established by CareFirst. In the case of travel or temporary residence outside the Service Area, benefits will be paid or provided for expenses incurred for treatment of an illness or injury only if:

1. The need for care could not reasonably have been foreseen before departing the Service Area or sufficiently in advance so as to permit the Member to return to the Service Area for the care before it became urgent;

2. The care was urgently required to alleviate acute pain or prevent further significant deterioration of the Member's condition;

3. The Member could not, without medically harmful results, return to the Service Area to receive treatment;

4. CareFirst determines that the travel was for some purpose other than the receipt of medical treatment; and,

5. CareFirst determines that the services were Medically Necessary.

B. In the case of a Hospital that has an emergency department, benefits include:

1. Appropriate medical screening;

2. Assessment and stabilization services; and

3. Ancillary services routinely available to the emergency department, to determine whether or not an Emergency condition exists.

C. A provider is not required to obtain prior authorization or approval from CareFirst in order to obtain reimbursement for Emergency services.

D. A Hospital, or other provider, or CareFirst, when CareFirst has reimbursed the provider, may attempt to collect payment from a Member for health care services that do not meet the criteria for Emergency services.

E. Except as provided below, benefits are not provided for routine follow-up treatment within the Service Area provided by non- Provider Network Providers. Follow-up treatment outside of the Service Area is covered if required in connection with a covered out-of-area Emergency or Urgent Care and CareFirst determines that the member could not reasonably be expected to return to the Service Area for such care.

9.3 Notice to CareFirst in the event of an Emergency.

A. If the Member is admitted to a Hospital as a result of an Emergency, CareFirst must be notified the earlier of:

1. The end of the first business day after first receiving the care; or

2. Within 48 hours after first receiving the care.

B. If it was not reasonably possible to give notice, this requirement will be met if notice was given as soon as reasonably possible. The Member must provide information about the Emergency and the care received. If the Member does not return to the Service Area and transfer care to a Contracting Physician or Provider Network Provider as soon as, in the judgment of CareFirst, the Member was able to do so without medically harmful results, no further benefits will be provided for services received on or after such date.

9.4 Ambulance Services.

A. Benefits are available for Medically Necessary ambulance services to or from the nearest Hospital or as authorized and approved by CareFirst.

B. If a Member is outside of the United States and requires treatment for Emergency services, benefits are provided for Medically Necessary air and ground transportation to the nearest facility where appropriate medical care is available.

9.5 Filing a Claim for a non- Provider Network Provider. A Member must submit a completed claim form to CareFirst within 90 days from the time services were first received. A claim form will be provided to the Member upon request. The Member is also responsible for providing information requested by CareFirst including medical records. If it is not reasonably possible to submit the completed claim form within the required time, the claim shall be submitted as soon as reasonably possible and, except in the absence of legal capacity, not later than one (1) year from the date that the submission of the claim was required.

9.6 Follow-up Care after Emergency Surgery. If CareFirst authorizes, directs, refers, or otherwise allows a Member to access a hospital emergency facility or other urgent care facility for a medical condition that meets the criteria for Medical Emergency, as defined in the evidence of coverage, and requires emergency surgery:

A. Coverage shall be provided for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's PCP; and

B. The Member will be responsible for the same copayment for each follow-up visit as would be required for a visit to a Contracting Physician for specialty care.

SECTION 10
MEDICAL DEVICES

MEDICAL DEVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST

10.1 **Covered Benefits**. Benefits will be provided for Medical Devices when:

A. Obtained from a designated Provider Network Provider; and

B. The Member has coverage under the evidence of coverage at the time that the Durable Medical Equipment, Prosthetic, Orthotic Device, or Medical Supply is prescribed and received. The Member must continue to be eligible for coverage for the duration of time for which Durable Medical Equipment is rented.

10.2 **Authorization or Approval of Medical Devices by CareFirst**. Benefits are limited to the least expensive Medically Necessary Durable Medical Equipment, Medical Supply, Orthotic Device or Prosthetic adequate to meet the patient's medical needs.

To qualify for coverage for Medical Devices, the Member or the provider must contact CareFirst prior to the purchase or rental of any Medical Device to obtain pre-approval of such purchase or rental. CareFirst will determine the Medical Necessity for the covered Medical Device and the appropriateness of the type of appliance, device, equipment or supply requested. CareFirst will then recommend the Provider Network Provider from whom the Member is authorized to obtain the Medical Device in order to receive benefits. Failure to contact CareFirst in advance of the purchase or rental and/or failure and refusal to comply with the authorization given by CareFirst will result in exclusion of the Medical Device from coverage.

10.3 **Responsibility of CareFirst**. CareFirst will not be liable for any claim, injury, demand or judgment based on tort or other grounds (including express or implied warranty of equipment) arising out of or in connection with the rental, sale, use, maintenance or repair of a Medical Device.

10.4 **Maximum Annual Limit**. Members receive benefits for covered Medical Devices up to the maximum annual limit, if any, stated in the Schedule of Benefits.

A. When a maximum annual limitation applies, total payments by CareFirst for Medical Devices, including covered maintenance, repair, and/or replacement costs, are limited to the maximum annual limit per Member.

B. If, during any benefit year, a Member exceeds his or her maximum annual limit, the Member will be responsible, throughout the remainder of that benefit year, for the full cost of any covered Medical Devices, including repair, maintenance and replacement costs.

C. Diabetic supplies, disposable syringes necessary to self-administer insulin, and other supplies for the treatment of diabetes are not subject to the maximum annual limit.

D. IUD's are not subject to the maximum annual limit.

E. Breast prostheses are not subject to the maximum annual limit.

10.5 **Definitions**.

A. **Medical Device**, as used in the Contract, means Durable Medical Equipment, Medical

Supplies, Prosthetic and Orthotic Device.

B. **Durable Medical Equipment** means equipment that:

1. Is primarily and customarily used to serve a medical purpose;

2. Is not useful to a person in the absence of illness or injury;

3. Is ordered or prescribed by a physician or other qualified practitioner;

4. Is consistent with the diagnosis;

5. Is appropriate for use in the home;

6. Is reusable; and can withstand repeated use.

C. **Medical Supply** means items that:

1. Are primarily and customarily used to serve a medical purpose;

2. Are not useful to a person in the absence of illness or injury;

3. Are ordered or prescribed by a physician or other qualified practitioner;

4. Are consistent with the diagnosis;

5. Are appropriate for use in the home;

6. Cannot withstand repeated use;

7. Are usually disposable in nature.

D. **Orthotic Device** means items that:

1. Are primarily and customarily used to serve a therapeutic medical purpose;

2. Are prescribed by a Health Care Provider;

3. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;

4. May be purely passive support or may make use of spring devices; and

5. Include devices necessary for post-operative healing.

E. **Prosthetic Device** means a device which:

1. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or

2. Is primarily intended to replace all or part of an organ or body part that was

absent from birth; or

3. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and

4. Is prescribed by a Health Care Provider; and

5. Is removable and attached externally to the body.

10.6 Covered Services.

Durable Medical Equipment

Rental, or, (at CareFirst's option), purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a Health Care Provider for therapeutic use for a Member's medical condition.

Durable Medical Equipment or supplies associated or used in conjunction with Medically Necessary medical foods.

CareFirst's payment for rental will not exceed the total cost of purchase. CareFirst's payment is limited to the least expensive Medically Necessary Durable Medical Equipment, adequate to meet the Member's medical needs. CareFirst's payment for Durable Medical Equipment includes related charges for handling, delivery, mailing and shipping, and taxes.

Hair Prosthesis. Subject to limitations, if any, set forth in the Schedule of Benefits, benefits for a hair prosthesis are available for a hair prosthesis when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.

Coverage for Medical Foods. Medically Necessary medical foods for inherited metabolic diseases and inborn deficiencies of amino acid metabolism when ordered by a Health Care Provider qualified to provide the diagnosis and treatment in the field of metabolic disorders, as determined by CareFirst.

Orthotic Devices, Prosthetic Devices

Benefits include:

1. Supplies and accessories necessary for effective functioning of Covered Service;

2. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and

3. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

10.7 Exclusions. Specific exclusions related to Medical Devices are listed with the Exclusions at the end of this Description Of Covered Services.

SECTION 11
LIMITATIONS AND EXCLUSIONS

11.1 Conditions for a Referral to a Non-Contracting Specialist.

A referral to a Specialist who is not a Contracting Physician or Provider Network Provider shall be provided if:

1. The Member is diagnosed with a condition or disease that requires specialized medical care;

2. There is no Contracting Physician or Provider Network Provider with the professional training and expertise to treat the condition or disease; and

3. The non-contracting Specialist agrees to accept the same reimbursement as would be provided to a specialist who is a Contracting Physician or Provider Network Provider.

11.2 Continuing Care with Terminated Providers.

A. When a Provider Network Provider terminates their agreement with CareFirst, for any reason except for cause, benefits will be provided for continuing care rendered by the terminated provider as described in this Section. CareFirst will send a notice to the Member that the Provider Network Provider is no longer available.

B. The Member may, upon request, continue to receive Covered Services from his/her PCP for up to 90 days after the date of the notice of the PCP's termination from CareFirst's provider panel, if termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status. In addition, a Member may continue treatment with a terminated provider if:

1. A Member was in an active course of treatment with the terminated Provider Network Provider prior to the date the Member was notified. The Member needs to request, from CareFirst, to continue receiving care from the terminated Provider Network Provider. Benefits will be provided for a period of 90 days from the date the Member is notified by CareFirst that the terminated Provider Network Provider is no longer available.

2. A Member who has entered her second trimester of pregnancy may continue to receive Covered Services from the terminated Provider Network Provider through postpartum care directly related to the delivery.

3. A Member that was terminally ill (as defined by § 1861(dd)(3)(A) of the Social Security Act) at the time the Provider Network Provider's agreement terminated may continue to receive Covered Services directly related to the treatment of the terminal illness until the Member dies.

11.3 CareFirst Personnel Availability for Preauthorization.

CareFirst requires preauthorization for certain medical treatment as stated in the evidence of coverage. Check the specific description of the Covered Services for a notice regarding

preauthorization. CareFirst shall have personnel available to provide preauthorization at all times when such preauthorization is required.

11.4 Coverage Is Not Provided For:

A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.

Notwithstanding any provisions regarding ancillary services to the contrary, payment for inpatient ancillary services may not be denied solely based on the fact that the denial of the hospitalization day was appropriate. A denial of inpatient ancillary services must be based on the Medical Necessity of the specific ancillary service. In determining the Medical Necessity of an ancillary service performed on a denied hospitalization day, consideration must be given to the necessity of providing the ancillary service in the acute setting for each day in question.

B. Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst.

C.

This exclusion will not be used, however, to deny Patient Cost when a clinical trial meets the criteria set forth in Section 1, above.

D. The cost of services that:

1. Are furnished without charge; or

2. Are normally furnished without charge to persons without health insurance coverage; or

3. Would have been furnished without charge if a Member was not covered under the evidence of coverage or under any health insurance.

E. Services that are not described as covered in the Contract or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Referral by a PCP and/or the provision of services by a Provider Network Provider does not, by itself, entitle a Member to benefits if the services are non-covered or do not otherwise meet the conditions and criteria for coverage.

F. Routine, palliative, or Cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

G. Routine dental care such as services, supplies, or charges directly related to the care, filling, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth.

H. Cosmetic services (except for Mastectomy—Related Services and services for cleft lip or cleft palate or both).

I. Treatment rendered by a Health Care Provider who is the Member's parent, child,

grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.

J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under this evidence of coverage. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility. Benefits for prescription drugs may be available through a rider or endorsement purchased by the Group and attached to the evidence of coverage.

K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services. Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.

L. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.

M. Services to reverse voluntary, surgically induced infertility, such as a reversal of sterilization.

N. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; physical conditioning; use of passive or patient-activated exercise equipment.

O. Treatment for weight reduction and obesity except for the surgical treatment of Morbid Obesity.

P. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.

Q. Services furnished as a result of a referral prohibited by law.

R. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst.

S. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.

T. Acupuncture services except when approved or authorized by CareFirst when used for anesthesia.

U. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a health care provider.

V. Any service received at no charge to the Member in any federal hospital or facility, or

through any federal, state or local governmental agency or department, not including Medicaid. This exclusion does not apply to care received in a Veteran's Hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.

W. Inpatient private duty nursing.

X. Non-medical, provider services, including, but not limited to:

1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.

2. Administrative fees charges by a Health Care Provider to a Member to retain the Health Care Provider's medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Contract are limited to Covered Services rendered to a Member by a Health Care Provider.

Y. Educational therapies intended to improve academic performance.

Z. Vocational rehabilitation and employment counseling.

AA. Treatment of temporomandibular joint disorders unless otherwise stated.

BB. Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.

CC. Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.

DD. Habilitative Services

1. Services delivered through early intervention and school services.

2. Habilitative Services for a Member 19 years and older.

11.5 <u>Infertility Services</u>. Coverage will not be provided for:

A. Any costs associated with freezing, storage, and thawing of the female Member's eggs and/or male Member's or donor sperm for future attempts.

B. IVF procedures and any related testing or service that includes the use of donor eggs.

C. Any charges associated with donor eggs.

D. Costs associated with the freezing and storage of fertilized eggs (embryos).

E. No infertility services (Artificial Insemination/Intrauterine Insemination or In-Vitro Fertilization) in which a surrogate is involved will be covered.

F. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures are not covered. When the Member has had a reversal of an elective male or female surgical sterilization procedure then:

1. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of infertility of at least 2 years' duration following the reversal of an elective sterilization procedure in order for IVF procedures to be covered.

2. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of at least 1 year of unprotected vaginal intercourse following the reversal of an elective sterilization procedure in order for artificial insemination to be covered.

G. All self-administered fertility drugs. Coverage will be provided for self-administered in-vitro fertilization drugs if the Group does not provide a Prescription Drug Benefits Plan.

11.6 Organ and Tissue Transplants. Coverage is not provided for:

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary, non-experimental skin grafts that are covered under the evidence of coverage.

B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.

C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.

D. Services for a Member who is an organ donor when the recipient is not a Member.

E. Benefits will not be provided for donor search services.

F. Any service, supply or device related to a transplant that is not listed as a benefit in the evidence of coverage.

11.7 Inpatient Hospital Services. Coverage is not provided for:

A. Private room, unless Medically Necessary and authorized or approved by CareFirst. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.

B. Non-medical items and Convenience Items, such as television and phone rentals, guest trays and laundry charges..

C. Except for covered Emergency Services and Maternity Care, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private duty nursing unless authorized or approved by CareFirst.

11.8 Home Health Care Services. Coverage is not provided for:

A. Private duty nursing unless authorized or approved by CareFirst.

B. Custodial Care.

C. Services in the Member's home if it is outside the Service Area.

11.9 Hospice Benefits. Coverage is not provided for:

A. Services, visits, medical equipment or supplies that are not included in CareFirst-approved plan of treatment.

B. Services in the Member's home if it is outside the Service Area.

C. Financial and legal counseling.

D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.

E. Chemotherapy or radiation therapy, unless used for symptom control.

F. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.

G. Reimbursement for volunteer services.

H. Custodial Care, domestic or housekeeping services.

I. Meals on Wheels or similar food service arrangements.

J. Rental or purchase of renal dialysis equipment and supplies.

K. Private duty nursing unless authorized or approved by CareFirst.

11.10 Outpatient Mental Health and Substance Abuse. Coverage is not provided for:

A. Psychological testing, unless Medically Necessary, as determined by CareFirst, and appropriate within the scope of Covered Services.

B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director.

C. Mental retardation, after diagnosis.

D. Psychoanalysis.

11.11 Inpatient Mental Health and Substance. Coverage is not provided for:

A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director.

B. Custodial Care.

C. Observation or isolation.

11.12 Emergency Services and Urgent Care. Coverage is not provided for:

A. Emergency care, if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).

B. Medical services rendered outside of the Service Area that could have been foreseen by the Member prior to departing the Service Area.

C. Charges for Emergency and Urgent Care services received from a non-Provider Network Provider after the Member could reasonably be expected to travel to the nearest Provider Network Provider.

D. Charges for services when the claim filing and notice procedures stated in Section 9 of the evidence of coverage have not been followed by the Member.

E. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the Emergency or Urgent Care facility outside of the Service Area unless CareFirst determines that the Member could not reasonably be expected to return to the Service Area for such care.

F. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Provider Network Provider.

G. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency as defined in Section 7.

11.13 Medical Devices. Coverage is not provided for:

A. Convenience Item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoyer/stair lifts, ramps, shower/bath bench.

B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.

C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, e.g. exercycle or other physical fitness equipment.

D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.

E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids (except as otherwise provided herein for minor children). Benefits for eyeglasses and contact lenses may be available through a rider or endorsement purchased by the Group and attached to the evidence of coverage.

G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.

ATTACHMENT B1

SCHEDULE OF BENEFITS

HIGH OPTION

<table>
<tr><th colspan="2">HIGH OPTION GENERAL PLAN BENEFIT FEATURES</th></tr>
<tr><td colspan="2">DEDUCTIBLES</td></tr>
<tr><td>In-Network Deductible

There is no In-Network Deductible.</td><td>Out-Of-Network Deductible

The Individual Deductible is $300 per calendar year

The Family Deductible is $600 per calendar year

The following amounts apply to the Out-of-Network Deductible:

• 100% of the Allowed Benefit for covered Out-of-Network services that are subject to the Deductible, as stated in the Benefits Chart below.</td></tr>
<tr><td colspan="2">Out-Of-Network Deductible

If you have Individual Coverage, you must meet the Individual Deductible.

If you have Two-Party Coverage, each Member must satisfy his own Deductible by meeting the Individual Deductible.

If you have Family Coverage, you can satisfy your Deductible by meeting the Individual Deductible. In addition, eligible expenses of all covered family members can be combined to satisfy the Family Deductible. An individual family member cannot contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible is met in this manner, this will satisfy the Deductible for all covered family members.

The following amounts may <u>not</u> be used to satisfy the Out-of-Network Deductible:

• Copayments for Covered Services;
• Amounts incurred for failure to comply with the Utilization Management Requirements;
• The portion of any provider charge that is in excess of the Allowed Benefit.

The Benefits Chart, below, states whether a covered service is subject to a Deductible. If a Deductible applies, the Chart will also states whether a Deductible applies to In-Network Benefits, Out-of-Network Benefits, or both.</td></tr>
</table>

OUT-OF-POCKET LIMITS
In-Network and Out-of-Network
The Individual Out-of-Pocket Limit is $1,000 per calendar year for both In-Network and Out-of-Network Services.
In-Network and Out-of-Network
These amounts apply to the Out-of-Pocket Limit except as noted below: • Coinsurance for Covered Services When you have reached the Out-of-Pocket Limit, no further Coinsurance or Deductibles will be required in that calendar year for covered services. Your Out-of-Pocket Limit applies on a calendar year basis even though you may have been enrolled for less than a calendar year. The following amounts may not be used to meet the In-Network or Out-of-Network Out-of-Pocket Limits: • Amounts incurred for failure to comply with the Utilization Management Requirements; • The portion of any provider charges which is in excess of the Allowed Benefit; • The Deductible and Copayments; • Charges for services which are not covered under this Contract or which exceed the maximum number of covered visits/days under your coverage.
Maximum Combined Out-Of-Pocket Limit
If you are using a combination of In-Network and Out-of-Network services, this feature avoids having to meet two separate Out-of-Pocket Limits. Your total Out-of-Pocket expenses (In-Network and/or Out-of-Network combined) are limited to your Out-of-Network Out-of-Pocket Limit amount. You can meet the Maximum Combined Out-of-Pocket Limit through any combination of In-Network and/or Out-of-Network Out-of-Pocket Limit expenses. If you meet your Maximum Combined Out-of-Pocket Limit, this automatically satisfies your In-Network and Out-of-Network Out-of-Pocket Limits for that year. When you have reached the Maximum Combined Out-of-Pocket Limit, no further Coinsurance or Copayments will be required in that calendar year.
LIFETIME MAXIMUM
There is no Lifetime Maximum.
UTILIZATION MANAGEMENT NON-COMPLIANCE
Failure or refusal to comply with Utilization Management Requirements for Out-of-Network Services will result in: Benefits for all services associated with your care or treatment will be reduced by 20%.

BENEFITS

IN-NETWORK BENEFITS

Each family member must select a PCP from our current list of In-Network Physicians. You may elect to participate in either the CareFirst BlueChoice Point-of-Service network or the Maryland Point-of-Service network. Your choice of PCP determines which network you are participating in. If you chose to see a provider outside your chosen network (other than a specialist to which you have been referred, your benefits will be available at the out-of-network level.

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When a Copayment is required for In-Network services, as noted below, you will pay the same Copayment amount whether you see your PCP or a Specialist.

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
PHYSICIAN AND PROVIDER SERVICES				
Preventive Services				
Child Wellness (Including related lab tests and immunizations)	Up to age 18	100% of the Allowed Benefit, minus a Member Copayment of $10 per office visit	NO	80% of the Allowed Benefit
Adult Preventive Physical Examinations (Including related services and immunizations)	Age 18 and older Limited to 1 per calendar year	100% of the Allowed Benefit, minus a Member Copayment of $10 per office visit	YES	80% of the Allowed Benefit
Screening Mammography	Age 35-39: One baseline mammogram of each breast. Age 40 - 49: One preventive mammogram of each breast every two calendar years or more frequently if recommended by a physician. Age 50 and above: One preventive mammogram of each breast per calendar year.	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Routine Pap Tests Including Related Office Visits	Limited to 1 per calendar year	100% of the Allowed Benefit, minus a Member copayment of $10 per office visit	NO	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Prostate Cancer Services	NONE	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Osteoporosis Prevention and Treatment Services	NONE	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Diagnostic and Treatment Services				
Office Visits	NONE	100% of the Allowed Benefit, minus a Member Copayment of $10 per office visit	YES	80% of the Allowed Benefit
Allergy Testing and Shots (including Serum)	NONE	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Maternity and Related Services	Benefits are available for the Subscriber and covered Dependents	100% of Allowed Benefit minus a Member Copayment of $10 per office visit; for maternity care, no copayment after first visit per pregnancy Sterilizations and reversals of sterilizations are not subject to the $10 copayment	YES	80% of the Allowed Benefit
In Vitro Fertilization	Limited to 3 attempts per live birth not to exceed a lifetime benefit of $100,000	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Surgical Care	Benefits apply on an inpatient or an outpatient basis	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Inpatient Medical Care	Covered only if hospitalization qualifies for coverage	100% of Allowed Benefit	YES	80% of the Allowed Benefit
Anesthesia Service (related to Acupuncture when used as a general anesthetic) (including covered general anesthesia for dental care)	Benefits apply on an inpatient or outpatient basis when provided in connection with a covered procedure General anesthesia for dental care must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Rehabilitation Therapy (speech, occupational, and physical)	Limited to 90 visits per calendar year per diagnosis for In-Network services (separate visits for each type of therapy) Out-of-Network Services not limited Note: There are no limits to Rehabilitation Therapy provided for Cleft Lip, Cleft Palate, or Both	100% of Allowed Benefit	YES	80% of the Allowed Benefit
Spinal Manipulation Services	Benefits for chiropractic/spinal manipulation services are limited to Members who are twelve (12) years of age or older	100% of Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
Outpatient Private Duty Nursing	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Acupuncture Therapy	Covered for pain management where traditional methods were tried and failed	100% of the Allowed Benefit minus a Member Copayment of $10 per office visit	YES	80% of the Allowed Benefit
Emergency Treatment Initial care received within 72 hours after onset	NONE	100% of the Allowed Benefit minus a Member Copayment of $10 per office visit	NO	Covered at the In-Network level for (bona-fide emergencies)
Ambulance Service:				
To or From Hospital	NONE	100% of the Allowed Benefit	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)
Foreign Transportation	Applies only if Member is traveling outside the U.S.	100% of the Allowed Benefit	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
HOSPITAL SERVICES				
Inpatient Hospital Services	Must be authorized in advance under Utilization Management Requirements Your In-Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Inpatient and Outpatient Hospital Services performed by Radiologist, Anesthesiologist, Pathologist and Surgical Assistants		100% of the Allowed Benefit	No	Covered at the In-Network level (for services provided by Non-Participating Providers)
Outpatient Hospital Services				
Emergency Room Treatment Initial care received within 72 hours after onset	NONE	100% of the Allowed Benefit, minus a Member Copayment of $25 per visit Waived if admitted to the hospital	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)
Cardiac Rehabilitation	Limited to 90 days per calendar year	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Organ Transplant	Limited to 365 days beginning 5 days before the day on which the Transplant is performed. Benefit Maximum of $1,000,000 for each type of covered transplant. Donor Organ Procurement limited to $50,000 per transplant Recipient Transportation and Lodging limited to: $150 per day, and $10,000 per Organ Transplant	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
HOME HEALTH CARE	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf Limited to 90 visits (up to four hours per visit) per calendar year for In and Out-of-Network Services	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
SKILLED NURSING FACILITY SERVICES	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf In-Network and Out-of-Network Services (Combined) limited to 100 days per calendar year	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
HOSPICE CARE SERVICES	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf Bereavement Counseling is limited to the 6 month period following the Member's death or 15 visits, whichever occurs first In-Network Services not limited Respite Care is limited to 14 days per Benefit Period Note: Benefits for Bereavement Counseling extend beyond the Hospice Eligibility Period	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
Outpatient Services				
Medication Management Office Visits	NONE	100% of the Allowed Benefit minus a Member Copayment of $10	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
Office or Outpatient Facility	Visit maximums are combined In and Out-of-Network	Per calendar year: Visits 1-5: 100% of the Allowed Benefit Visits in excess of 5: 70% of Allowed Benefit	YES	Per calendar year: Visits 1-5: 80% of the Allowed Benefit Visits 6-30: 65% of the Allowed Benefit Visits in excess of 30: 50% of the Allowed Benefit
Neuropsychological Testing		80% of the Allowed Benefit	YES	80% of the Allowed Benefit
Methadone Maintenance Treatment		100% of Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount	NO	100% of Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount
Partial Hospitalization	Must be authorized in advance under Utilization Management Requirements Limited to 60 days per calendar year Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
Hospital Inpatient	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Psychiatric Halfway House	Must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
MEDICAL DEVICES AND SUPPLIES	Must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Hair Prosthesis	Benefits are limited to one hair prosthesis per calendar year	100% of the Allowed Benefit up to $350 for one hair prosthesis	NO	100% of the Allowed Benefit up to $350 for one hair prosthesis
Hearing Aids for Minor Children	Benefits are limited to one Hearing Aid for each hearing-impaired ear once every 36 months	100% of the Allowed Benefit up to $1400 for each ear	NO	100% of the Allowed Benefit up to $1400 for each ear

ATTACHMENT B2

SCHEDULE OF BENEFITS

STANDARD OPTION

<table>
<tr><th colspan="2">STANDARD OPTION GENERAL PLAN BENEFIT FEATURES</th></tr>
<tr><td colspan="2">DEDUCTIBLES</td></tr>
<tr><td>In-Network Deductible

There is no In-Network Deductible.</td><td>Out-Of-Network Deductible

The Individual Deductible is $300 per calendar year

The Family Deductible is $600 per calendar year

The following amounts apply to the Out-of-Network Deductible:

• 100% of the Allowed Benefit for covered Out-of-Network services that are subject to the Deductible, as stated in the Benefits Chart below.</td></tr>
<tr><td colspan="2">Out-Of-Network Deductible

If you have Individual Coverage, you must meet the Individual Deductible.

If you have Two-Party Coverage, each Member must satisfy his own Deductible by meeting the Individual Deductible.

If you have Family Coverage, you can satisfy your Deductible by meeting the Individual Deductible. In addition, eligible expenses of all covered family members can be combined to satisfy the Family Deductible. An individual family member cannot contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible is met in this manner, this will satisfy the Deductible for all covered family members.

The following amounts may <u>not</u> be used to satisfy the Out-of-Network Deductible:

• Copayments for Covered Services;
• Amounts incurred for failure to comply with the Utilization Management Requirements;
• The portion of any provider charge that is in excess of the Allowed Benefit.

The Benefits Chart, below, states whether a covered service is subject to a Deductible. If a Deductible applies, the Chart will also states whether a Deductible applies to In-Network Benefits, Out-of-Network Benefits, or both.</td></tr>
</table>

OUT-OF-POCKET LIMITS
In-Network and Out-of-Network
The Individual Out-of-Pocket Limit is $1,000 per calendar year for both In-Network and Out-of Network Services.
In-Network and Out-of-Network
These amounts apply to the Out-of-Pocket Limit except as noted below: • Coinsurance for Covered Services When you have reached the Out-of-Pocket Limit, no further Coinsurance or Deductibles will be required in that calendar year for covered services. Your Out-of-Pocket Limit applies on a calendar year basis even though you may have been enrolled for less than a calendar year. The following amounts may <u>not</u> be used to meet the In-Network or Out-of-Network Out-of-Pocket Limits: • Amounts incurred for failure to comply with the Utilization Management Requirements; • The portion of any provider charges which is in excess of the Allowed Benefit; • The Deductible and Copayments; • Charges for services which are not covered under this Contract or which exceed the maximum number of covered visits/days under your coverage.
Maximum Combined Out-Of-Pocket Limit
If you are using a combination of In-Network and Out-of-Network services, this feature avoids having to meet two separate Out-of-Pocket Limits. Your total Out-of-Pocket expenses (In-Network and/or Out-of-Network combined) are limited to your Out-of-Network Out-of-Pocket Limit amount. You can meet the Maximum Combined Out-of-Pocket Limit through any combination of In-Network and/or Out-of-Network Out-of-Pocket Limit expenses. If you meet your Maximum Combined Out-of-Pocket Limit, this automatically satisfies your In-Network and Out-of-Network Out-of-Pocket Limits for that year. When you have reached the Maximum Combined Out-of-Pocket Limit, no further Coinsurance or Copayments will be required in that calendar year.
LIFETIME MAXIMUM
There is no Lifetime Maximum.
UTILIZATION MANAGEMENT NON-COMPLIANCE
Failure or refusal to comply with Utilization Management Requirements for Out-of-Network Services will result in: Benefits for all services associated with your care or treatment will be reduced by 20%.

BENEFITS
IN-NETWORK BENEFITS Each family member must select a PCP from our current list of In-Network Physicians. You may elect to participate in either the CareFirst BlueChoice Point-of-Service network or the Maryland Point-of-Service network. Your choice of PCP determines which network you are participating in. If you chose to see a provider outside your chosen network (other than a specialist to which you have been referred, your benefits will be available at the out-of-network level. When a Copayment is required for In-Network services, as noted below, you will pay the same Copayment amount whether you see your PCP or a specialist. PCP Copayment - $15 Specialist Copayment - $30

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
PHYSICIAN AND PROVIDER SERVICES				
Preventive Services				
Child Wellness (Including related lab tests and immunizations)	Up to age 18	100% of the Allowed Benefit, minus a Member Copayment of $15 per office visit Specialist Copayment of $30 per office visit	NO	80% of the Allowed Benefit
Adult Preventive Physical Examinations (Including related services and immunizations)	Age 18 and over Limited to 1 per calendar year	100% of the Allowed Benefit, minus a Member Copayment of $15 per office visit Specialist Copayment of $30 per office visit	YES	80% of the Allowed Benefit
Screening Mammography	Age 35-39: One baseline mammogram of each breast. Age 40 – 49: One preventive mammogram of each breast every two calendar years or more frequently if recommended by a physician. Age 50 and above: One preventive mammogram of each breast per calendar year.	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Routine Pap Tests Including Related Office Visits	Limited to 1 per calendar year	100% of the Allowed Benefit, minus a Member Copayment of $15 per office visit. Specialist Copayment of $30 per office visit	NO	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Prostate Cancer Services	NONE	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Osteoporosis Prevention and Treatment Services	NONE	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Diagnostic and Treatment Services				
Office Visits	NONE	100% of the Allowed Benefit, minus a Member Copayment of $15 per office visit Specialist Copayment of $30 per office visit	YES	80% of the Allowed Benefit
Allergy Testing and Shots (including Serum)	NONE	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Maternity and Related Services	Benefits are available for the Subscriber and covered Dependents	100% of Allowed Benefit minus a Member Copayment of $30 for first office visit; for maternity care No additional copayments after first visit per pregnancy Sterilizations and reversals of sterilizations are not subject to the $30 copayment	YES	80% of the Allowed Benefit
In Vitro Fertilization	Limited to 3 attempts per live birth not to exceed a lifetime benefit of $100,000	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Surgical Care	Benefits apply on an inpatient or an outpatient basis	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Inpatient Medical Care	Covered only if hospitalization qualifies for coverage	100% of Allowed Benefit	YES	80% of the Allowed Benefit
Anesthesia Service (including Acupuncture when used as a general anesthetic) (including covered general anesthesia for dental care)	Benefits apply on an inpatient or outpatient basis when provided in connection with a covered procedure General anesthesia for dental care must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Rehabilitation Therapy (speech, occupational, and physical)	Limited to 90 visits per calendar year per diagnosis for In-Network services (separate visits for each type of therapy) Out-of-Network Services not limited Note: There are no limits to Rehabilitation Therapy provided for Cleft Lip, Cleft Palate, or Both	100% of Allowed Benefit	YES	80% of the Allowed Benefit
Spinal Manipulation Services	Benefits for chiropractic/spinal manipulation services are limited to Members who are twelve (12) years of age or older	100% of Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
Outpatient Private Duty Nursing	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Acupuncture Therapy	Covered for pain management where traditional methods were tried and failed	100% of the Allowed Benefit minus a Member Copayment of $30 per office visit	YES	80% of the Allowed Benefit
Ambulance Service				
To or From Hospital	NONE	100% of the Allowed Benefit	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)
Foreign Transportation	Applies only if Member is traveling outside the U.S.	100% of the Allowed Benefit	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
HOSPITAL SERVICES				
Inpatient Hospital Services	Must be authorized in advance under Utilization Management Requirements Your In-Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit minus the $150 Member copay	YES	80% of the Allowed Benefit
Inpatient and Outpatient Hospital Services performed by Radiologist, Anesthesiologist, Pathologist and Surgical Assistants		100% of the Allowed Benefit	No	Covered at the In-Network level (for services provided by Non-Participating Providers)
Outpatient Hospital Services				
Emergency Room Treatment Initial care received within 72 hours after onset	NONE	100% of the Allowed Benefit, minus a Member Copayment of $35 per visit. Waived if admitted to the hospital	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)
Cardiac Rehabilitation	Limited to 90 days per calendar year	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Organ Transplant	Limited to 365 days beginning 5 days before the day on which the Transplant is performed. Benefit Maximum of $1,000,000 for each type of covered transplant. Donor Organ Procurement limited to $50,000 per transplant Recipient Transportation and Lodging limited to: $150 per day, and $10,000 per Organ Transplant	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
HOME HEALTH CARE	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf Limited to 90 visits (up to four hours per visit) per calendar year for In and Out-of-Network Services	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
SKILLED NURSING FACILITY SERVICES	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf In-Network and Out-of-Network Services (Combined) limited to 100 days per calendar year	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
HOSPICE CARE SERVICES	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf Bereavement Counseling is limited to the 6 month period following the Member's death or 15 visits, whichever occurs first In-Network Services not limited Respite Care is limited to 14 days per Benefit Period Note: Benefits for Bereavement Counseling extend beyond the Hospice Eligibility Period	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
Outpatient Services				
Medication Management Office Visits	NONE	100% of the Allowed Benefit minus a Member Copayment of $15 Specialist Copayment of $30 per office visit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
Office or Outpatient Facility	Visit maximums are combined In and Out-of-Network	Per calendar year: Visits 1-5: 100% of the Allowed Benefit Visits in excess of 5: 70% of Allowed Benefit	YES	Per calendar year: Visits 1-5: 80% of the Allowed Benefit Visits 6-30: 65% of the Allowed Benefit Visits in excess of 30: 50% of the Allowed Benefit
Neuropsychological Testing		80% of the Allowed Benefit	YES	80% of the Allowed Benefit
Methadone Maintenance Treatment		100% of Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount	NO	100% of Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount
Partial Hospitalization	Must be authorized in advance under Utilization Management Requirements Limited to 60 days per calendar year Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

Service	Special Limitations	Plan Covers		
		In-Network	out of Network Deductible?	Out-of Network
Hospital Inpatient	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Psychiatric Halfway House	Must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
MEDICAL DEVICES AND SUPPLIES	Must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Hair Prosthesis	Benefits are limited to one hair prosthesis per calendar year	100% of the Allowed Benefit up to $350 for one hair prosthesis	NO	100% of the Allowed Benefit up to $350 for one hair prosthesis
Hearing Aids for Minor Children	Benefits are limited to one Hearing Aid for each hearing-impaired ear once every 36 months	100% of the Allowed Benefit up to $1400 for each ear	NO	100% of the Allowed Benefit up to $1400 for each ear